DOCUMENT RESUME

ED 344 400 EC 301 129

AUTHOR	Pawl, Jeree, Ed.
TITLE	Learning through Supervision and Mentorship.
INSTITUTION	National Center for Clinical Infant Programs, Arlington, VA.
REPORT NO	ISSN-0736-8083
PUB DATE	Dec 91
NOTE	45p.
AVAILABLE FROM	Zero to Three, National Center for Clinical Infant Programs, 2000 14th St., North, Suite 380, Arlington, VA 22201-2500 ($18.00 per year).
PUB TYPE	Collected Works - Serials (022)
JOURNAL CIT	Zero to Three; v12 n2 Dec 1991
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	At Risk Persons; *Disabilities; *Early Intervention; *Family Programs; *Infants; Mentors; Professional Development; Program Administration; *Staff Development; Staff Role; *Supervision; Supervisory Methods

ABSTRACT

This newsletter theme issue focuses on the value of supervision in developing personnel in programs for infants with disabilities and their families. The first article, titled "Learning through Supervision and Mentorship To Support the Development of Infants, Toddlers and Their Families" (Emily Fenichel), is an essay explaining the thinking of the National Center for Clinical Infant Programs' Work Group on Learning through Supervision and Mentorship. The essay discusses the essential features of supervision and mentorship, including reflection, collaboration, and regularity. "The Professionalization of Early Motherhood" (William M. Schafer) describes four developmental stages in the professionalization of early motherhood that is demanded of the infant mental health specialist. The four stages are the crisis of acceptability as an attachment figure, the crisis of competence to be a maternal figure, crisis of commitment to remain a maternal figure, and crisis of confidence in the outcome of one's maternal activity. "The Supervisory Relationship: Integrator, Resource, and Guide" (Rebecca Shahmoon Shanok) looks at what the supervisee and supervisor each bring to the relationship and at the ways learning takes place within it. "A Seminar for Supervisors in Infant/Family Programs: Growing versus Paying More for Staying the Same" (Judith Bertacchi and Frances M. Stott) describes a supervision seminar based on psychodynamic theory that provides a forum for exchange and helps directors broaden their professional identity to include new competencies. Other articles include: "Supervision as a Catalyst in the Evolution of an Integrated Infant Mental Health/Developmental Intervention Program" (Barbara Ivins and Nancy Sweet); "Management in the South Carolina Resource Mothers' Program: The Importance of Supervision" (Madie A. Robinson); "Toward Tenacity of Commitment: Understanding and Modifying Institutional Practices and Individual Responses That Impede Work with Multi-problem Families" (Barbara Fields); "Knowing the Players" (Kyle D. Pruett); and "Scenes from Supervision" (Judith Pekarsky). (JDD)

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
E. Schrag
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

ED344400

Zero to Three

Bulletin of
NATIONAL CENTER FOR CLINICAL INFANT PROGRAMS VOL. XII. NO. 2, DECEMBER 1991 ISSN 0736-8083

Learning through Supervision and Mentorship To Support the Development of Infants, Toddlers and Their Families

by

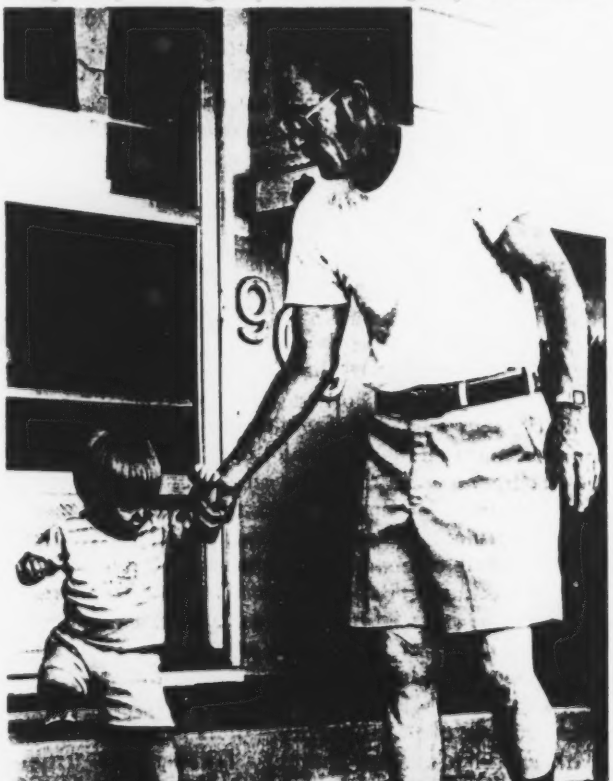
Emily Fenichel, with the
NCCIP Work Group on Supervision and Mentorship

This essay is a work in progress. It represents a stage in the evolving thinking of the National Center for Clinical Infant Programs' work group on Learning through Supervision and Mentorship. Members of the group are Judith Bertacchi, Barbara Fields, Linda Gilkerson, Judith Pekarsky, Kyle Pruett, Madie Robinson, Rebecca Shahmoon Shanok, Eva Thorp, Marcy Whitebook, and Carol Lou Young-Holt; staff are Emily Fenichel and Linda Eggbeer. The work of this group is being supported by the Center for the Future of Children of the David and Lucile Packard Foundation; Deanna Gomby is Director of Research and Grants, Child Development.

Supervision and mentorship are relationships for learning. In the world of professional practice with infants, toddlers and their families, supervision and mentorship provide regular opportunities for individuals and groups, less experienced and more experienced, in training and service settings, to reflect together about their hands-on work.

Just as services to support the development of infants, toddlers and their families take many forms, so do the supervision and mentorship arrangements designed to support the development of practitioners in this field. Indeed, the terms "supervision" and "mentorship" themselves are understood very differently across the disciplines and service systems that work with young children and their families.

In a one-year project currently underway at the National Center for Clinical Infant Programs, a multidisciplinary work group is examining supervision and



FLORENCE SHARP

EC 301129

Contents:

Learning through Supervision and Mentorship ... p.1
Knowing the Players ... p.7
The Professionalization of Early Motherhood ... p.10
The Supervisory Relationship ... p.16
Scenes from Supervision ... p.20
Supervision as a Catalyst in an Infant Mental Health/Development Intervention Program ... p.22
Management in the South Carolina Resource Mothers' Program ... p.27
Toward Tenacity of Commitment ... p.30
A Seminar for Supervisors in Infant/Family Programs ... p.34
National Center Notes ... p.40
Publications ... p.40
Conference Call ... p.43

National Center for Clinical Infant Programs *2000 14th St., North, Suite 380, Arlington, VA 22201-2500* *(703) 528-4300*

mentorship in the context of the range of practice with infants, toddlers and their families. As we try to describe and demystify supervision and mentorship, we are looking at both differences and similarities across disciplines and settings. We have discovered that experienced administrators, trainers, and practitioners seem to agree on the essential features of effective supervision and mentorship in this field. These are:

- reflection;
- collaboration; and
- regularity.

In this essay, part of a larger report that will be published by NCCIP in the spring of 1992, we describe and discuss reflection, and the collaboration and regularity that support reflection, as essential features of supervision and mentorship in infant/family training and practice. Before doing so, however, we address the special characteristics of infant/family practice that make supervision and mentorship essential for delivery of high quality services and that make these relationships particularly appropriate vehicles for teaching and learning in this field.

The special characteristics of infant/family practice

Work with infants, toddlers and their families takes many forms in this country. These forms are constantly evolving. The health care system touches virtually all infants and mothers, however fleetingly. Some form of out-of-home child care is part of the experience of a majority of infants, toddlers, and families. Early intervention services for very young children with special needs and their families are becoming increasingly widespread. Formal and informal family resource programs, of widely varying size, scope and sponsorship, flourish in many communities. Infant mental health services are provided by private practitioners, free-standing or institutionally based clinics, or consultants to other service settings. Community planners, federal and state administrators, and private foundations are experimenting with service system changes designed to address effectively the multiple, often complex needs of families with young children. One consequence of this diversity is that people who work with infants, toddlers and their families come from a range of professional and non-professional backgrounds, may or may not have been trained specifically to work with young children and/or families, and are certain, in the course of their careers, to encounter novel challenges.

During the last half-decade, a consensus has been developing around principles that lead to quality in infant/family programs. Such principles are reflected, among other places, in accreditation standards for service programs and for professionals, in field-based program evaluation and longitudinal research, and in the specifications of requests for proposals issued by federal and state agencies serving diverse populations of infants, toddlers, and their families. Thoughtful front-line practitioners and administrators in the field are likely to agree that:

Zero to Three Staff
Editor—Jeree Pawl
Associate Editor—Emily Fenichel
Consulting Editor in Pediatrics—Jack Shonkoff

Zero to Three is a publication of the National Center for Clinical Infant Programs. Unless otherwise noted, materials published in Zero to Three may be reproduced by health professionals or employees, officers or board members of non-profit education and social services organizations for non-commercial use, provided they acknowledge the National Center for Clinical Infant Programs as the source and copyright owner of this material.

National Center for Clinical Infant Programs
Board of Directors
Kathryn Barnard—University of Washington
T. Berry Brazelton—Children's Hospital Medical Center, Boston
Amy S. Cohen—Center for Preventive Psychiatry, White Plains
Robert N. Emde—University of Colorado School of Medicine
Linda Gilkerson—The Evanston Hospital and Erikson Institute, Chicago
Morris Green—Indiana University School of Medicine
Stanley I. Greenspan—George Washington University School of Medicine
Robert J. Harmon—University of Colorado School of Medicine
Irving B. Harris—Pittway Corporation, Chicago
Asa Grant Hilliard, III—Georgia State University, Atlanta
Anneliese Korner—Stanford University Medical Center
J. Ronald Lally—Far West Laboratory, San Francisco
Bernard Levy—Smart Parts, Inc., NYC
Alicia F. Lieberman—University of California, San Francisco
Samuel Meisels—University of Michigan
Dolores Norton—University of Chicago
Robert Nover—George Washington University School of Medicine
Joy Osofsky—Louisiana State Univ. Medical Center, New Orleans
Jeree Pawl—University of California, San Francisco
George H. Pollock—Northwestern Memorial Hospital
Sally Provence—Yale University School of Medicine
Kyle Pruett—Yale University School of Medicine
Arnold Sameroff—Brown University School of Medicine
Marilyn M. Segal—Nova University, Ft. Lauderdale, Florida
Rebecca Shahmoon Shanok—Jewish Board of Family and Children's Services, NYC
Jack Shonkoff—University of Massachusetts Medical School
Albert J. Solnit—Yale University School of Medicine
Lynn Straus—Mamaroneck, NY
Bernice Weissbourd—Family Focus, Inc.
G. Gordon Williamson—JFK Medical Center, Edison, New Jersey
Edward Zigler—Yale University

Life Members
Mary D. Salter-Ainsworth-University of Virginia
Peter Blos, Jr.—Ann Arbor, Michigan
Peter B. Neubauer—New York City
Arthur H. Parmelee—University of California Medical Center Los Angeles
Julius B. Richmond—Harvard University Medical School
Mary Robinson—Baltimore, Maryland
Pearl Rosser—Silver Spring, Maryland

Executive Director: Eleanor Stokes Szanton
Associate Director: Carol Berman
Associate Director: Emily Fenichel
Senior Program Associate: Peggy Pizzo

This publication was made possible in part by grants from Johnson and Johnson Consumer Products, Inc. and the New-Land Foundation

© National Center for Clinical Infant Programs 1991

- Services for infants, toddlers and their families must be specially designed for this population in order to be developmentally appropriate. They cannot be scaled-down versions of programs for older children.
- Infants and toddlers must be understood and served within the context of their families.
- Families are the constants in a child's life; the job of the professional is to assist families in supporting the child's development.
- Services to infants, toddlers and their families must be individualized to respect and build on unique constitutional, developmental, and cultural characteristics.
- Service coordination should be available to ease families' access to the range of services they require.
- Policy and practice should recognize and build on the capacities, resilience, and resourcefulness of children and families.

The extent to which such principles are actually applied in a service program or institution depends to a large extent on the competence of staff. Competence, in turn, depends on the skill, commitment, and personal qualities of front-line practitioners. It also depends on the ability of program designers, administrators, and managers to enable front-line practitioners to use their individual talents fully and to work effectively together.

To use one's individual talents fully in work with infants, toddlers and their families is no easy task. Such work engages the emotions as fully as the intellect. Very young children stir powerful feelings in adults (the species is programmed that way). Moreover, parents and parent-child interaction evoke complex responses in professionals that are often difficult to sort out and respond to in ways that support the parent, the child, and the relationship between them. The practitioner must learn to take advantage of her* individual skills and gifts. She must also become more aware of aspects of her work that are troublesome—including areas she is prone to overlook. She must come to terms with the realization that no single individual can possibly meet all the professional demands she is likely to encounter in working with children from birth to three and their families.

The infant/family practitioner is likely to encounter high caseloads, physical demands, paperwork, inadequate resources within and beyond her work setting, and expectable tensions among colleagues. She will have to find ways to cope with these current realities of infant/family practice, or ways to change them.

The very words and phrases that we have used to describe responses to the challenges of work with infants, toddlers and their families—"sort out," "become aware," "cope,", "change", "realize"—suggest that **reflective** practice is a key element of **"best"** practice in our field. We suggest further that the job of enabling students and practitioners to become reflective professionals can be accomplished, in large part, by collaborative, regular supervision and mentorship.

We have chosen to use the female pronoun when referring to practitioners and supervisors since the overwhelming majority of infant/family professionals is female. Unless otherwise stated, however, points apply equally well to male practitioners and supervisors.

NANCY P. ALEXANDER

Supervision and mentorship: More than temporary relief from distress

Efforts to implement principles of best practice in work with infants, toddlers, and their families yield a host of daily, emotionally charged dilemmas for service providers and administrators. Comments around the coffee pot or copy machine are revealing:

"I went to school to learn to work with children—not babies, and not parents."

"I'm the only 'baby person' here."

"I couldn't say anything about the baby's language development, the way I had planned to in this month's home visit, because Mrs. P. never stopped talking about Mr. P."

"When Mr. and Mrs. P. were finally ready to take Joey for an assessment at Mercy, their so-called team of so called experts talked down to the P's and acted as if I were invisible. I'd like to murder the whole 'multidisciplinary' crew."

"I have so many families to see that I can't be really helpful to any of them."

"I have so much stuff to enter into the computer that I can't see my families."

"I just got back from the Qs' house. How could a human being let a baby suffer so? I don't see how I can go back there."

"Copy machine commiseration" may offer temporary relief from discomfort caused by limitations in professional training, changing job demands, and the

inevitable stresses of working with people. In contrast to casual "support," supervision and mentorship offer **ongoing** opportunities to recognize, understand, and cope successfully with the challenges of becoming an infant/family practitioner—just as practitioners offer opportunities for support and growth to parents, and parents to children. Supervisory and mentorship relationships embody what some call the golden rule of supervision: "Do unto others as you would have them do unto others."

Supervisory and mentoring relationships provide opportunities for the individual participant to:

- Deepen and broaden knowledge;
- Reflect regularly, in a safe environment, on the full range of reactions to the experience of practice;
- Discuss individual goals and measure progress toward them;
- Develop and refine one's professional use of self and individual style, through increased self-understanding;
- Examine the philosophy that underlies an approach to infants, toddlers and their families, as it is expressed in the policies and practices of a professional discipline or service setting; and
- Learn from a more experienced practitioner who describes why and how she works as she does—and discusses both successes and failures in the course of her own professional development.

Supervisory and mentorship relationships provide opportunities for educators and administrators to:

- Model a mutually respectful, collaborative approach to monitoring performance and maintaining an acceptable level of service to children and families;
- Model a mutually respectful, collaborative relationship that parallels the supervisee/family relationship;
- Offer information and instruction that are relevant to the individual learner's level of professional development and immediate practice needs;
- Support individual practitioners, particularly as they deal with the stressful aspects of work with infants, toddlers and their families; and
- Create and maintain an overall climate of intellectual inquiry, open communication, empathy with staff concerns, and support for the long-term professional development of staff.

A note of caution must be sounded here. People who have had satisfying experiences as a supervisee or supervisor, protegee or mentor, value these relationships highly. One seasoned administrator of a large, multi-service agency calls supervision "the greatest gift I can give my staff." A student reflects that supervision by a mentor teacher helped her to "take on experience in a manageable chunk." But people who have **not** had positive personal experience with reflective, collaborative, regular supervisory or mentoring relationships often, quite literally, "don't know what they are missing." They may think of supervision as, at worst, "checking up on," and, at best, measuring the adequacy of performance against some fixed list of competencies.

In addition, people who work with infants and toddlers are often victims of the myth that working with babies should "come naturally"—at least to women. This idea may account for the belief that extensive training is unnecessary for effective practice with infants, toddlers and their families. It may explain the sense, common among infant/family practitioners, that they should dismiss or be ashamed of feelings toward infants or parents that reflect anything other than a wish to help. It may mean that when a supervisor encourages a trainee to explore new ways of responding to a baby or family, this encouragement is seen as a judgment that the worker lacks some expectable skill or information, and as a threat to the supervisee's basic self esteem and sense of security.

Simply to label as "misperceptions" such widely and deeply held beliefs about supervision is not likely to diminish their influence upon either practice or policy. An alternative way of perceiving the supervisory or mentoring experience and relationship must be offered. We hope that our effort to identify core features of supervision and mentorship as they occur in the specific context of work with infants, toddlers and their families will be a first step in such an approach.

Essential features of supervision and mentorship in infant/family training and practice

The knowledge and skills of many professional disciplines find a place in the wide range of settings that serve infants, toddlers and their families. Similarly, different traditions of supervision and mentorship are being adapted for use in training and practice in our multidisciplinary field. It is important to recognize that a variety of supervisory and mentoring models may offer similar opportunities to staff for learning and reflection. At the same time, identical terms—including "supervision" and "mentorship" themselves—may have quite different meanings, depending on discipline and setting.

In the midst of all this diversity, many experienced administrators, trainers, and practitioners seem to agree that **reflection, collaboration,** and **regularity** are the essential features of effective supervision and mentorship in the infant/family field. These features seem to be important to the supervision and mentoring of both students and practitioners, although emphasis and nuances may be different for each group.

Reflection

Reflection can be thought of as both the means and the end of the process of supervision. Reflection involves stepping back from the immediate, intense experience of hands-on work. Depending on the "contract" she establishes with her supervisor, the supervisee provides material for mutual consideration—written process notes from a meeting with a child and family, an oral narrative, a curriculum or treatment

plan, behavior recorded on audiotape or videotape or observed directly by the supervisor. The supervisor or mentor offers an enlarged perspective, another pair of eyes, a mirror. From the dialogue between supervisee and supervisor emerges, one hopes, a clearer vision of the work in progress.

Reflection means continuing conceptualization of what one is observing and doing. It is required of the supervisor or mentor as well as of the student or less experienced practitioner. "What were you thinking about when you did that?" is a question that either partner in a supervisory or mentoring relationship can ask the other, and that the experienced practitioner continually asks herself. Consequently, the first step in learning to be a supervisor often involves articulating the principles underlying one's own practice—for example, why does one set up the physical environment this way? What are the advantages and disadvantages of visiting weekly instead of monthly (or monthly instead of weekly)? What is one looking for and wondering about as one seems (to the trainee) to be saying or doing so little? Why does one learn from paying attention to one's emotional responses to working with individual children and families? The more supervisors or mentors are able to conceptualize their own practice, the better prepared they are to help trainees understand principles and formulate possible solutions to the challenges at hand.

Sometimes, of course, reflection fails to yield clarity. Experienced supervisors often say that one of the chief benefits of supervision is an increased tolerance for ambiguity, even for helplessness. People who are drawn to work with infants, toddlers and their families want to help if not to heal—to *do* something. Virtually all trainees underestimate the value of the relationship itself, of "being there" for and with a child and family. It is the supervisor or mentor who listens to the frustrated trainee and can say, "This is really complicated. I 'm not sure what I would do in these circumstances. It will get clearer as you continue with the family. We do know that you are an important presence in their life." Because supervision and mentorship are processes and relationships, not sequenced courses of instruction, such difficult messages, and others, can be delivered repeatedly, as "teachable moments" present themselves—and as supervisors and mentors "are there" for students and workers.

Reflection in the course of supervision and mentorship helps the trainee come to terms with what it means to go beyond doing what "comes naturally" to help babies or parents—to become a professional who works with infants, toddlers and their families. Part of the process of developing a professional identity involves recognizing the need to enlarge one's own knowledge, skills, and sensitivity. Supervisors and mentors can direct the trainee to relevant materials and demonstrate, or even role play specific techniques. They can help supervisees develop skills in observing infants, toddlers, and their families and in using their observations in responsive, reflective practice. The diverse demands of infant/family work make experiences with supervisors and mentors from a range of disciplines and traditions particularly useful for the trainee. Indeed, transdisciplinary practice in early intervention requires that colleagues be able to teach their perspectives and skills to each other.

It is important to remember, however, that many students and practitioners find it much easier to ask for information or technical advice than to reflect on the feelings they experience as they work with babies and families. Supervisors and mentors can reinforce (or introduce) the idea that emotions are the basic stuff of parents' and children's relationships. By attending to her own affective experience, the worker may be able to learn more about what children and families are feeling. As the supervisee's own emotional responses are acknowledged and respected, she may become increasingly able to acknowledge, respect, and respond sensitively to the emotional experiences and expressions of infants, toddlers, families and colleagues.

Reflecting on professional identity also involves examining values. The complexities of daily practice may bring the student or worker face to face with conflicts between competing priorities, clashes between traditional and innovative approaches, policies that seem to disregard or undermine the well-being of young children or families, and evidence that her own work is not valued. In the words of one veteran administrator, "In this field, you have to fight so hard to do what you love, and the world out there isn't even sure what you're doing." Supervisors and mentors can help trainees shape questions with which to probe and ponder their own behavior, beliefs, and values, as well as those of the programs, institutions, and service systems in which they are working. Such discussions, of course, may prompt supervisors and mentors to thoughtful reflection and change as well. One area involving behaviors, beliefs and values that represents a source of conflict for many supervisors and administrators—especially women—concerns the exercise of authority. Supervisors and mentors need to resolve their own conflicts about exercising authority before they can establish clear expectations for their students or employees.

It takes time to feel comfortable with a professional identity, just as it takes time to "become" a student, a colleague, a parent or a spouse. Supervisors and mentors can provide a relationship and an environment in which the trainee's professional identity can emerge gradually, until what once seemed "tacked on" becomes a core part of the trainee's sense of self.

How does one learn to reflect? Some educators suggest preparing students early on to use the experience of supervision or mentorship. In the classroom, teachers can encourage students to question conventional wisdom and their own thinking and decision making. In supervised practice or internships, supervisors and mentors can take time to discover what each trainee brings to this hands-on training, in order

to guide and support the supervisee's reflection. Program managers and administrators encourage reflection in the work setting not only by providing opportunities for individual supervision but also by encouraging thoughtful, open communication in daily activity. As the experienced practitioner acquires and values the habit of reflection, the process comes full circle—the reflective practitioner prepares to become the supervisor or mentor.

Collaboration

The experience of supervision or mentorship in work with infants, toddlers and their families has been described as like "having a friend on a difficult journey." As practitioners who work in a wide range of settings talk about the "rich and troubling" intellectual and emotional challenges they face, they speak of their field as a "frontier." No one knows for sure what lies ahead; new information pours in, but may be unreliable; the strategies of early pioneers may or may not be appropriate for those who wish to establish permanent settlements. One doesn't want to travel through uncharted territory alone.

Supervision has also been described as offering "the occasional bliss of the collaborative state." While we believe that the development of close professional relationships may be one of the most rewarding aspects of working in our new and challenging field, we must admit that "bliss" is likely to be only "occasional" in any human relationship. But nourishing, enduring, rewarding, "good enough" collaborative supervisory and mentoring relationships can become established parts of any training or work environment—if we recognize the foundations upon which such relationships are built. These elements, which are not unique to infant/family work, are power, mutual expectations, and communication.

Power in a collaborative relationship is shared power. In supervisory and mentorship relationships in the infant/family field, power derives from knowledge, not just experience or conviction. Just as a parent is the expert on his or her own child, so the supervisee is the authority on her own work experience. In addition, the supervisee or protegee brings to a relationship her life experience as child and perhaps as parent, as a participant in at least one culture and perhaps as an observer of others, and as a member of racial and gender groups. Not uncommonly, the supervisee or protegee will have academic or clinical expertise that is directly relevant to work with infants, toddlers and their families and that surpasses that of the supervisor or mentor in at least some areas. This will certainly be the case in peer supervision arrangements, which depend in large part on the pooling of expertise and the contribution of different perspectives to common understanding.

Power can be held mutually without being shared equally. Supervisors of students are likely to be responsible for evaluating the supervisee's performance and growth; supervisors in service settings may have specific responsibility within the organization for assuring the quality of services provided to children and families. But when the evaluative function is shared, the process of reflection encourages ongoing self-evaluation by the supervisee. Periodic formal evaluations become occasions for a systematic review of what have been continuing conversations between supervisor and supervisee. Again, as in family life or a therapeutic relationship, one hopes to see shifts in the balance of power over time. With experience comes movement from greater dependence on authority to fuller autonomy (although "interdependence" rather than an illusory "independence" should be the lifelong goal of the infant/family professional).

Clear mutual expectations seem to be critical to the success of a collaborative supervisory or mentoring relationship. The supervisory "contract" clarifies the boundaries and responsibilities of each participant in this unique relationship. Participants need to agree on the logistics of their arrangement—where and when they will meet. They need to agree on the content that they will look at together—this might include on-the-job performance, directly observed; written notes of itneractions with children and families; an oral account of the trainee's experience with children, families, colleagues; reflection on the supervisory relationship itself.

Some disciplines use a model of regular, formal cycles in which supervisor and supervisee together negotiate planning, observation, analysis, and critique of performance. In other models, the supervisor tries informally to learn as much as she can about the supervisee early in the relationship, and freely discloses her own clinical experience. Mutual candor and trust are expected to facilitate the kind of highly interactive discussion that makes supervision or mentorship "not a course, but a process." Observations, ideas, feelings, connections, questions, and recurring themes are all welcomed as part of an unfolding, deeply meaningful, and mutually built conversation. Even (or, perhaps, especially) in this type of supervisory relationship, there must be clear mutual understanding about the boundaries and distinctions between supervision and friendship, and supervision and therapy. And the supervisory "contract" may need to be re-negotiated periodically.

In some circumstances, expectations must be clarified among three parties. In the context of a student practicum or internship, for example, roles and responsibilities must be established for the student intern, the field supervisor, and the faculty member or academic program director. Field supervisors and faculty members need support and opportunities to expand their roles as much as students do. As the range and variety of infant/family practice expands, "multi-level " supervisory and mentorship models increase as well. For example, a state-level training and technical assistance agency may match mentors and protegees from different service programs, or leaders of a multi site research and demonstration project may use their periodic site visits to help project staff at various levels reflect on their work.

Knowing the Players

Kyle D. Pruett, M.D.
Clinical Professor of Psychiatry
Yale Child Study Center

When the supervision process which supports our work with infants and their families is working well, it functions as a relationship used to understand relationships. When not working well, it is a relationship that can inhibit, rather than foster understanding. In our experience, good supervision, like good intervention, takes time, involves large quantities of uncertainty, is based on mutual trust, is sometimes frustrating, but is ultimately mutually enriching and satisfying.

My thoughts here are focused on the prelude to these satisfactions, or how supervision begins with its best foot forward. How do supervisor and supervisee get to know each other, and what do they need to know to get this job started well?

As supervisor and supervisee rarely have the opportunity to choose one another, getting to know one or another should not be a process taken for granted. Both should have the opportunity of contributing to the charting of the course before them. Introductions are in order before the journey begins. How do these people get to know each other, and what do they need to know in order to be useful to each other? I've always found it useful, and at the very least entertaining, to talk right at the very beginning about why and how we both found our way into this unusual field of endeavor. The stories we both tell form the narrative or dialogue of our convictions about what we shall do together.

Secondly, what is the language we will be using together? What theoretical models, no matter how simple, are useful to us both? The language must be *jointly* accessible and both must be explicitly granted permission to ask, "What do you *mean* . . . ?"

Third, what has the supervisees' previous experience of supervision been, and what did they find most useful about it? More importantly, what did they not find useful? Equally important is the supervisor's description of how he or she supervises best. This should not be a guessing game between the two, left to intuition or mind reading. No two supervisors supervise identically. No two supervisees expose their work identically either.

Despite how well the process begins, most supervisees feel less powerful and authoritative than they assume the supervisor feels. The reverse is closer to the truth. The supervisor's usefulness to the supervisee is directly proportional to the accuracy and depth of the material brought to him or her by the supervisee. The more the supervisor knows about the more sensitive and sometimes vulnerable aspect of the supervisee's work with the family, the greater the supervisor's usefulness and the greater the learning, growth, or more appropriately, developmental opportunity for the supervisee. Self-disclosure by the supervisor about similar sensitivities and vulnerable aspect of the supervisee's work with the family, the greater the supervisor's usefulness and the greater the learning, growth, or more appropriately, developmental opportunity for the supervisee. Self-disclosure by the supervisor about similar sensitivities and vulnerabilities can often assist the process at its most difficult points.

The parallel processes which drive supervision and intervention are unendingly fascinating to those of us who strive to improve our clinical skills. When the players know each other, the pleasure in the playing begins sooner, lasts longer, and is more free of errors.

The kind of **communication** that occurs within a collaborative supervisory or mentoring relationship in the field of infant/family practice may be the element that contributes most often to "occasional bliss." Such communication flows freely in both directions. It is open between participants, yet protected from outsiders. This kind of communication is highly suited to its specific task of examining professional work with infants, toddlers and their families. For such work is itself designed to foster communication, establish trust on a bedrock of confidentiality, and strengthen human relationships. One may use the term "parallel process" or speak of "doing unto others as you would have them do unto others," but the meaning remains the same. Open communication between supervisor and supervisee can be seen as a model for communication between professionals and parents, and between parents and children.

Regularity

Time is a scarce resource in programs that serve infants, toddlers, and their families. Daily demands are immediate and unrelenting, with little if any "down" time for staff. Funding patterns create pressure to spend as much time as possible in direct service; at the same time, reporting requirements consume hours of effort. The rapid pace of development during the first three years adds an extra sense of urgency to infant/family work: timing is critical, and missed opportunities for preventive intervention can be costly to child and family. Finally, the awareness of unmet need haunts every thoughtful practitioner in the field.

There is no getting around it, however. To be worthy of the name, supervision or mentorship must occur regularly. Time must be allocated for these relationships, and this time must be protected. It takes time to reflect, time to collaborate, and above all time to establish trust in the reliable nature of the relationship itself. The parallels with parent/infant and parent/professional relationships are clear.

Although they may argue eloquently for the importance of investing in very young children and their families, practitioners and administrators who work with this population are often reluctant to invest in

the professional development of their staff members or themselves. Administrators may resist allocating time and staff for regular supervision or mentorship on the grounds that staff should "already know" how to do their jobs, or because basic services to as many children as possible must take precedence over improving, or even maintaining, the quality of planning or performance.

Infant/family training and service programs vary enormously in the amount of **time** they allocate to supervision or mentorship, but the importance of **regularity** is universally emphasized. If scheduling regular supervision by the calendar seems extraordinarily difficult, it may nevertheless be possible to build collaborative reflection into an already regularly occurring process. For example, individual, group, or peer supervision could become a step in the development of every Individualized Family Service Plan (IFSP) for infants, toddlers, and families served under Part H of the Individuals with Disabilities Education Act. The beginning of a program year or the entrance of a new child or family into an ongoing service program could be used as occasions for staff reflection, as an integral part of assessment and planning.

In sum ...

While supervision and mentorship take many forms and build on many traditions in work with infants, toddlers, and their families, reflection, collaboration, and regularity seem to characterize virtually all effective supervisory and mentorship relationships in this diverse field. Resources are more likely to be scarce than abundant in any setting that serves very young children, but trainers and administrators who are convinced of the value of supervision or mentorship find endlessly creative ways to offer these experiences to their students and staff.

As NCCIP's Learning through Supervision and Mentorship project continues, we are eager to find out more about *Zero to Three* readers' experiences, needs, and ideas concerning supervision and mentorship. We are interested in responses to the ideas we have set out in this article, and in information that will help us to think more clearly about the "outstanding issues" listed on p. 8-9. Write, call, or send a FAX to Emily Fenichel or Linda Eggbeer, NCCIP, 2000 14th Street North, Suite 380, Arlington, Virginia 22201, tel: (703) 528-4300, FAX: (703) 528-6848.

Oustanding issues in supervision and mentorship

Years of experience tell us a great deal about the value of supervision and mentorship as they occur in programs that serve infants, toddlers and their families, and in settings that prepare practitioners to work with this population. Yet many important questions await more complete and coherent responses from the field.

Some of the questions listed below could be answered empirically, given sufficient resources; others are likely to require some thoughtful reframing before they are meaningful.

1. Do most training programs for infant/family personnel include a supervised field experience with children 0-3 and their families?

This apparently straightforward question is in fact quite complex. Conceptions of supervision and requirements for field experience differ greatly among the professional disciplines concerned with infants, toddlers and their families. It would be important to learn whether training programs with an infant/toddler specialization—whatever the auspices—are moving toward a model of supervision that emphasizes reflection (including observation), collaboration, and regularity.

It is also important to remember that many people who work with infants, toddlers and their families, particularly child care providers and community home visitors, begin work with no previous academic preparation for the job at all, let alone a supervised field experience.

2. Do all programs that serve infants, toddlers and their families incorporate some regular mechanisms for reflection and collaboration?

No, unfortunately. Observers of the child care system describe centers that have no regularly scheduled staff meetings and say that it is becoming increasingly common for child care providers, even in centers, to work alone with a group of infants or toddlers, with little or no opportunity to confer with other staff. These conditions represent an erosion of child care training and practice, which traditionally emphasized the role of the master teacher as supervisor, and colleagues as mentors.

Erosion of a supervisory tradition occurs in other disciplines and settings when resources diminish or the workload increases. Under these circumstances, case planning and crisis management tend to usurp time once dedicated to reflective supervision. With added stress and reduced support, the inner resources of workers are also depleted.

3. How much supervision is appropriate for trainees and workers at different levels of expertise and in different work settings?

Some disciplines specify the years or even hours of supervised practice necessary to attain a professional license. In ongoing practice, it would be reasonable to

assume that workers in particularly stressful settings might need more hours of supervision or more frequent supervision than others. However, students and practitioners bring individual strengths and vulnerabilities to diverse work settings, in which each child and family is also unique. A distinction also needs to be made between the use of supervision to establish or maintain an acceptable level of service and its use to encourage the maximum possible professional development of staff.

To develop recommendations for "best practice" relative to supervision and mentorship requires considerable analysis within the specific context of infant/family practice before reasonable hypotheses could be suggested.

4. *What commonalities and differences exist between supervision of trainees and supervision of employees? Between supervision of paraprofessionals and supervision of professionals in infant/family work?*

Whatever answers we may have thought we had to these questions deserve fresh scrutiny in light of current major expansions and reconceptualizations of practice with infants, toddlers and their families. People are seeking professional training virtually throughout the lifespan. Competencies and credentials are being re-examined across human services, nowhere more intensely than in practice with very young children and families. Attention is being paid also to recruitment, retention, and career development in the field.

We need to formulate a typology, or perhaps even a developmental paradigm, of goals, roles, and responsibilities for supervisees and supervisors at various stages of training and practice. As we do so, we must be mindful of the range of formal training, work experience, and personal knowledge that individuals may bring to supervisory and mentoring relationships. We must also consider the supports in the teaching or workplace environment that are necessary to make learning through supervision and mentorship possible.

5. *Many infant/family practitioners are women, often of childbearing age. What is the relevance of this phenomenon for supervision and mentorship?*

Campus-based educators often comment on the importance of understanding the life experience of their students as they encounter the emotional intensity of field-based practice. Supervision and mentorship give students the chance to confront and use their personal experience. Administrators and supervisors in clinical settings, particularly those serving infants and toddlers with medical or developmental problems, observe the value of supervision in helping practitioners who are thinking about or are actively involved in childrearing to cope with the feelings evoked by their work. A related issue has to do with the supervisory or administrative style of women. This issue is being written about to some extent in the business literature, but remains unexplored in the context of infant/family practice.

6. *Are supervision and mentorship cost effective?*

We don't know for sure, but our best guess is "yes." Administrators who provide extensive supervision say that good supervision is more of an incentive than salary in recruiting and retaining talented workers (although this is less likely to be the case in the lowest-paid occupations involved with infants, toddlers and their families). The argument has also been made that individualized supervision is less costly than didactic instruction in improving on-the-job performance. According to this argument, training that appears inexpensive (for example, brief workshops or conferences) may result in minimal improvement in staff performance and child outcomes. Higher investment in supervision and mentorship may bring proportionately greater yields. This would be an interesting hypothesis to test.

7. *How do people learn to be supervisors and mentors?*

With some exceptions, supervisors in the infant/family field tend to be promoted to their jobs, rather than trained for them. Not unlike first-time parents, they find themselves drawing, consciously or unconsciously, on their own experiences of being supervised, just as parents find themselves replicating or reacting against their own childhood experiences. Notable exceptions to this pattern do exist. Schools of social work offer courses in supervision, either as continuing education or in doctoral programs; some social work schools require that supervisors of students in field placements participate in a course on supervision. The early childhood special education program at the University of Illinois gives doctoral students supervised experience as they in turn supervise masters level students from several disciplines in their interaction with infants, toddlers and parents in a play group. The California Early Childhood Mentor Teacher Program offers experienced child care providers a course specifically geared to teaching them how to supervise and oversee students in a field experience. Graduates of the course may become mentor teachers, performing a new professional role and earning additional income, yet remaining in the classroom setting.

With or without formal training, supervisors in infant/family programs express a need for ongoing skills development, reflection, and support that is as urgent as that of front-line staff. Indeed, supervisors may feel even more isolated than front-line staff, since they may have no peers in their organizational structure. Supervisors want to refine and expand their clinical and management skills, including strategies for finding time and money for staff supervision within their program budgets. Community-based seminars for supervisors represent one promising response to these needs.

NCCIP's Work Group on Learning through Supervision and Mentorship is eager to hear readers' elaborations, additions, and responses to these questions. Please contact Emily Fenichel or Linda Eggbeer at NCCIP.

The Professionalization of Early Motherhood

by

William M. Schafer, Ph.D.
Ann Arbor, Michigan

The preparation for this paper began almost four and a half years ago when I had the privilege of attending a clinical retreat for infant mental health professionals, hosted by the Training and Education Committee of the Michigan Association for Infant Mental Health. The participants had come from all across the state, from urban centers and rural areas. They represented many different professions, working in hospitals, schools, community mental health centers, and private clinics. All had experience making home visits. All, with the exception of myself, were women.

On the day in question we discussed cases. We spent over an hour talking about a 16-year-old girl who successfully "hid" her pregnancy from her own mother, delivered her baby with her boyfriend's help in the back seat of a car, then left the baby girl on a crowded avenue in the hope someone would find her and care for her. The authorities were called in, and the baby spent five weeks in foster care. Then, largely at the grandmother's urging, the baby was returned to the teen-age mother. Now the authorities had called in the infant mental health specialist "to make sure everything would be okay."

We spent much time trying to enter into the emotional state of that 16-year-old girl in order to find words which might, just possibly, respond accurately enough to her inner experience to engage her in serious work on behalf of her baby. Then, perhaps even harder, we tried to do the same for the grandmother who had engineered the fateful reunion.

It was during this prolonged exercise of entering into the young girl's consciousness that I became aware of a profound shift occurring within the group. The conversation turned from clients to clinicians, and to the toll this work levies on their own inner life. Someone spoke of feeling drained of maternal energies. Another spoke of the lingering resentment she felt from her spouse. A third told of the complaints her children voiced at her work. People described their outlets and releases: music, aerobics, horseback riding, running, drawing (I recall a vivid description of drawings of doors without handles and walls with bars), and endless telephone calls to set up workable support groups. As I listened I was struck by the difficulty of juggling professional with domestic roles. Then I realized something which to me was new: these women were not talking about a conflict *between* job and motherhood, but of the conflict *within* a job that turned motherhood into a profession. Their careers demanded that they enter daily into realms of feeling ordinarily reserved for special and time-limited periods surrounding the birth of one's own children. The draining of maternal energies resulted from the professionalization of early motherhood demanded of the infant mental health specialist.

As I look back on that day I do not think it coincidental that such an awareness should dawn during a discussion of the feelings which exist between an adolescent mother and her own mother. The exercise of entering simultaneously into both of those emotional worlds was precisely, I believe, what turned the discussion from clients to clinicians. In an existential sense, early motherhood is the delicate emotional space hovering like a dimensionless point between one's own childhood and that of one's child. Since it is within this space that the infant mental health worker spends so much of her time, it is not surprising that she should frequently experience an ongoing preoccupation with her own personal existence as a woman.

Early motherhood is the delicate emotional space between one's own childhood and that of one's child. It is within this space that the infant mental health worker spends much of her time.

It is to that space, and to its development over time, that we now turn. For expository convenience I had originally intended to invent a hypothetical infant mental health specialist, and to follow her as she struggled with casework over the course of her career. But to do that I would have to invent a person, that is to say, I would have to endow her with a history. She would need to have this particular mother, this particular husband, this particular job, these children, and so on. In the end, her individuality would overshadow the more general developmental issues I wish to highlight today. I take some time and trouble to point this out, because I want to underscore my belief that in the long run our individual histories and the way they have shaped each of us are far more important to our eventual experience and conduct as clinicians than anything else. Although what we are talking about today is quite important, it remains secondary.

My thesis is that the professionalization of motherhood is an issue which one can think about as a normal developmental crisis occurring in four basic stages. I propose that the first of these could be called a crisis of one's acceptability as an attachment figure. It usually occurs as one enters the field, before one has had children of one's own. The second is a crisis of one's competence to be a maternal figure, and usually occurs during those years when the specialist is beginning her own family while simultaneously establishing herself as a member of her profession. The third is a crisis of commitment to remain a maternal figure, and spans the professional's maturing years, often ending in a series of crises commonly known as burnout. The fourth is a crisis of confidence in the outcome of one's maternal activity. It typically occurs after one's own children have grown, during those more mature years when one has begun to take on some responsibility for administering, supervising, teaching others who will one day take one's place in the field.

I. The Crisis of Acceptability

The young woman who enters the field of infant mental health directly from graduate school brings with her a wealth of information, expertise and knowledge about infancy and motherhood. If, however, she is herself unmarried or does not yet have children of her own, she may be able only to imagine what it must feel like to prepare for, deliver and tend to one's own baby. Her client has had a profoundly moving life experience which she herself has not yet had. The client has produced the baby for which part of the worker secretly yearns. Perhaps the worker had been able to graduate from her master's level program only because she had postponed marriage and/or childbearing. Such a choice is never made easily or unambivalently, but the full force of that ambivalence may suddenly descend upon her shoulders when faced with a client who has made the opposite choice, who actually has produced the longed-for baby, and who now says she doesn't love it.

Added to this is the fact that the entry level worker is new to clinical work. She has not yet had her first success. She has not even had her first client leave her. She carries with her many principles and tactics, but they are for the most part unpracticed and untried. She has been told over and over that the human relationship is the central element in any process of development, but she has not yet had the opportunity to experience such a relationship in a professional context. The closest she has been to an ongoing therapeutic process may be her own personal therapy. This can be a marvelous opportunity to learn what therapy feels like, and the new worker who is in therapy has a tremendous advantage over the one who is not, but it can have its disadvantages as well. For the young person who is just beginning to work with mothers and babies may also be a young person who has just come from her own therapy session where she was confronted by the full force of her angry disillusionments about her own mother. Now she is suddenly being asked to respond empathically to the needs of a woman who is openly neglectful or rejecting of a helpless child. The abrupt shift may be more than the worker can easily manage, with the result that she will be impelled into an unhealthy overidentification with the baby against the mother.

These issues of late adolescence and early adulthood, issues of separation from one's own parents, are ultimately the source of the crisis of acceptability. This is a time of life when a young woman is called upon to give up her adolescent fantasies about herself and her mother. The process involves two apparently contradictory yet dynamically related movements. On the one hand she must learn to revise her idealized constructions of her own mother and of herself. She has to give up the fantasy: "I had a perfect mother, and I was her perfect child." At the same time she must get in touch with the defensive wishes (and the pain they conceal) behind her lingering hostilities toward her mother. She has to give up the fantasy: "I did not have the perfect mother I deserved, which is the reason I never became a perfect child."

It is this struggle which the new infant mental health specialist brings to her clinical cases. As she offers herself as an attachment figure to each new client, part of her is hoping that she will be the client's perfect mother and the client will be her perfect baby. This wish is quickly frustrated by the client, who is brimming over with confusion and ambivalence about her baby, as well as about her worker. Then the specialist is tempted to retreat into a defensive stance in which part of her wants to tell her client that the client would have indeed found her a perfect mother, if only the client had been a better child.

It might be well for us to pause for a moment's reflection here. We are proposing that the crisis of acceptability as an attachment figure is rooted in the young worker's struggle to give up past illusions about her own mother. So far, that is nothing really very new. Is this not precisely the problem which is faced by any young social worker, nurse, or teacher, no matter which client population she serves? What is so special about the problem faced by the infant mental health worker? What makes this problem different?

The illusion that each birth is a new dawning of innocence gives us the faith we need as we attempt to renew ourselves through the birth of a new life. But it is an illusion that is meant to exist for a time only.

It is the presence of the infant in the midst of the work. The baby is the concrete embodiment of the human race's illusion of perfectibility. Each baby is the world's new hope for healing. Each birth is a new dawning of innocence which is still beyond damage or evil. This is a natural, a normal phenomenon. It is good that we at times yield to this illusion. It gives us the faith we need as we attempt to renew ourselves through the birth of a new life. But it is an illusion that is meant to exist for a time only, within that delicate space between two childhoods which we call early motherhood. The difficult challenge of the infant maternal health specialist is to learn to utilize the positive impetus of this illusion without being totally captivated by it. The special problem of her formative years is learning to harness the power this illusion holds over her client while she is simultaneously struggling to be liberated from its power over herself.

The resolution of the crisis of acceptability hinges upon the infant mental health specialist's acquisition of basic competency in her role. This competency in turn is comprised of two elements: her acquisition of basic intervention skills, and her growing confidence in her ability to enter empathically into the world of a mother-infant pair with positive results. The first is accomplished through continued training, supervision and support. The second would seem more difficult to acquire.

As it turns out however, the crisis of acceptability carries within itself the very terms of its own solution. If we look more closely, we can see that the beginning infant mental health specialist is offering herself to a client-

mother as an attachment figure without any prior experiential validation of her own worthiness to be such a figure. She has no history of successful outcomes, no memories of initially resistant parents who eventually found her invaluable, no mental pictures of competent babies who owe their competency in large part to her intervention. She can literally taste the cloud of doubt which surrounds her. And here she is, presenting herself to another young woman who is also offering herself as an attachment figure to her infant with little or nor experiential validation of her worthiness to be such a figure. Both client and clinician are for the moment joined by their common experience of self-doubt and by their need to resolve lingering conflicts over a common set of fantasies about themselves and their own mothers. And here lies the groundwork for a solution. If the new worker can be given the guidance and emotional safety to explore and to understand this troubling situation within herself, she can be led to a deeper and richer understanding of the client-mother's emotional world. No longer will she stand at the periphery of the mother-infant relationships, a stranger to its bittersweet intimacies; instead she will be a partner to its pulsing dance. And even if at first she fails to catch on, and her first few cases seem to fail, she will still be in possession of an experience which can potentially link her to many of the mothers she serves, mothers who are also taunted by their own secret lists of prior failures. In an odd sort of way, her doubts about her worthiness will be resolved to the extent she is carefully supported through her initial humiliations.

II. The Crisis of Competence

The growing competency of the infant mental health specialist ushers in a new phase of work, and with it a new problem. As the specialist becomes a more experienced clinician, she is also likely to be moving ahead in her own personal life. One of the most powerful events shaping her life now is likely to be her own entrance into motherhood. With motherhood comes direct experience of that delicate space between two childhoods. This creates a new ability to empathically share another mother's experience. It also introduces a new set of tensions.

The new infant—the specialist's child—is a strong competitor for her affection and energies. She may temporarily leave her job to be with her baby. This may bring a loss of money, of friendships, of self-esteem. Or she may continue to work. This may bring feelings of guilt or resentment as she drops her child off at day care in order to begin her visits to other children's homes. She cannot help but draw comparisons between her own and her clients' children, between herself and her client-mothers. She may feel a small surge of pride and relief at the thought that she and her own children seem to be so much happier, followed by a stab of shame that she should allow herself this secret pleasure. If the competitive impulse is not held in check, she may find herself offering herself more and more as an attachment figure to the client-infant, to the subtle exclusion of the client-mother. Or, and perhaps more commonly, she may begin to feel growing resentment toward those "other" professionals who serve children and families (but wihout the infant mental health background)—which, of course, makes them virtually useless!

These kinds of tension are signs that the specialist has embarked upon another segment of the long, complicated road from one's own childhood to one's children's. The earlier conflict over one's acceptability has been transformed into a conflict about one's own competence. The earlier fantasies about having or not-having a perfect mother have shifted slightly and become: "I *am* a better (worse) mother than my own, for I have produced a better (worse) baby."

Having a baby of one's own tends to normalize the whole range of feelings associated with early parenthood.

These issues of early parenthood—the lingering competition with one's own parents, the illusion that one might still become the perfect parent they failed to be—can complicate the clinical work of the younger specialist. But as in the case of the earlier crisis of acceptability, this current crisis also contains the elements of its own solution. Having a baby of one's own tends to normalize the whole range of feelings associated with early parenthood. One is able to experience for oneself the sense of being burdened and overwhelmed, the powerful wish for temporary escape, the welling up of resentments and anger. All of this serves to remedy one's earlier and somewhat naive visions of motherhood.

Actually, one's own baby can be a major force in helping to resolve this crisis. First of all, as one's baby passes through infancy into middle childhood, the basis for comparison with one's client-children tends to shrink. Secondly, it becomes obvious that one's own child, although competent and sturdy, is not *always* healthy, happy, and content. Consequently, it slowly becomes obvious that perfection is not necessary, either for the child or the parent. And most importantly, one becomes more fully aware that the child also has something of her own to say about how development shall proceed. All of this conspires to teach us that normal development has a somewhat broader range than we previously thought, and also that we cannot accept either total credit or total blame for everything that happens to our children.

A second major force in the resolution of the crisis can be found in one's professional life. One way to look at the crisis of competence is to understand it as a search for new bases of self-esteem, narcissistic supplies, and competitive victories. These can be obtained through setting up comparisons with one's clients, but that is not the only possibility. One can also search for these necessities in the arena of professional growth. As the infant mental health specialist gathers more experience she usually discovers that she now has something useful to say during staff meetings, case conferences and group discussions. She ceases to be the newest member of the

team. She may be asked to write up one of her cases and present it at a meeting. She may take on new responsibilities, earn higher wages, learn that she is recognized and valued by her fellow professionals. Thus, she discovers that she can sublimate many of her narcissistic and competitive impulses into her professional life, rather than simply repeat them with her clients.

III. The Crisis of Commitment

As times goes on, the infant mental health specialist may begin to feel that children fill her life from one end of the day to the other. There are all these client-children; then there are her own. They surround her until her life begins to seem like an endless preoccupation with infancy. She may learn to go through many facets of her day on a kind of automatic pilot. The initial poignancy of her first one or two really tragic cases diffuses somewhat, and she may experience her own inner reaction to new tragedies as less sharply focused but more broadly encompassing. It's the difference between a thunderstorm and an endlessly cloudy day.

It is at this point that she may begin to hear some rumblings of discontent. The first rumblings may actually come from her spouse, who complains about her seeming tired and preoccupied; or from her children, who complain about her being away from the house. When she talks with her colleagues about her work she tends to focus less upon specifics of case dynamics and intervention techniques, and more upon all the sadness and loss that is out there in the world. The rumblings of discontent now seem to be coming from somewhere within herself. She is beginning to ask why she has chosen to surround herself with babies and with the feelings they awaken. Somewhat paradoxically she may also be mulling over whether or not to have one last child of her own. At times she explicitly wonders whether she should look for a different kind of work.

We usually talk about this process under the heading of burnout. That is unfortunate, because the term burnout connotes running out of fuel. It implies some insufficiency within the individual. Admittedly, burnout is a very complicated question, involving all sorts of personal, psychological, maturational and social factors. But very often the feelings we describe as burnout are simply signals that the person stands at a developmental crossroad. Far from having run out of gas, the person is poised to cross a new threshold. Often what is needed is not a new job, but a new integration of career into one's personal life. For the infant mental health specialist, this entails a yet deeper understanding of how to work within the illusions of early motherhood without succumbing to their power.

We may recall that early motherhood is a time of pliability and openness. It is a time when psychological boundaries are allowed to relax. It is a period of continual giving to an other who needs to be nurtured. At so many different levels, it is an experience of profound self-lessness. However it is not meant to last, and we will cause ourselves endless trouble if we confuse this vision of early motherhood with motherhood in general, or worse yet, if we confuse early motherhood with being an infant mental health specialist.

People in our field are prone to a general belief, never quite stated as such, but there nonetheless, that we are the professionals who truly care about our clients. We pride ourselves on our openness to even the most painful emotional experiences, on our capacity to provide ongoing nurturance, care and support, and on our ability to intervene without confrontation or blame. We are, in a phrase, professional early mothers.

I believe that this is totally wrong. We are not professional early mothers; we are rather professionals who understand the implications of early motherhood. Learning the difference between these two visions of the profession is, I submit, the crucial task of gaining maturity as an infant mental health specialist.

We are not professional early mothers. We are rather professionals who understand the implications of early motherhood.

Let me give an example of that difference. The professional early mother makes repeated appointments with a client who is rarely at home, and then when they finally do meet says very little about the missed appointments. The professional who understands early motherhood also makes repeated appointments, but when the opportunity to meet does present itself she spends a great deal of energy trying to understand why the client has found it so difficult to meet with her. The first worker believes that she will build a relationship of trust by not troubling her client too much. The second trusts that she can build something positive only by talking about what troubles the relationship. We could alter the example, of course. We could examine how each behaves when a client displays heated anger or hostility toward her child, or what each does when shown the telltale signs of substance abuse. The specialist who is confused about her role will find herself placating anger rather than pursuing its cause, she will offer transportation rather than the truth, she will set up appointments that are inconvenient to her rather than set limits which will be helpful to her client. Somehow, the confusion will confound the clinical work. The specialist who believes she must be an early mother invariably ends up behaving more like an uncertain stepmother who tries to win her new child's love by giving in to his every whim—while in fact she is being unresponsive to his most important feelings of unhappiness and mistrust.

That same confusion may also show up in the specialist's personal life. She may feel somehow used and valueless, as though she has no right to her own happiness. She may find it hard to leave the tragedies at the office, and go about the business of enjoying her own life. Slowly, she may become a bit of a burden, first to her colleagues, then to her family, finally to herself.

Now there are many reasons why something like this should happen to a worker during her career. Many of

them are rooted in the individual's own history. Sometimes, however I think it has to do with the development of the particular set of fantasies about early motherhood we have been describing. We have seen how they began as a set of fantasies about *having* a perfect mother, then became a set of fantasies about *being* a perfect mother. In the crisis of commitment they take on a slightly different form, and might be worded thus: "Only if I remain the perfect *early* mother can I find perfect happiness." It is a fantasy based upon an inner belief that the only good mother is the infinitely giving, patient and selfless early mother. The *later* mother, however, who sets limits, promotes independence and maintains a life of her own is seen as a bad mother. This is a fantasy which seems particularly prevalent among those whose own mothers took very good care of them as infants, but didn't always know how to care for their emotional needs as they grew older, leaving them with a strong inner need to recapture some personal lost paradise, (perhaps through infant mental health work).

This fantasy of finding happiness only by remaining an early mother can also be accentuated by the events of middle life. As is often stated, mid-life is a time of being confronted by life's disappointments. One didn't get the house one always wanted, or the position or degree—or perhaps the spouse. Furthermore, the disappointments of mid-life are framed differently from those of earlier days because one's sense of time has changed. When one is young, tragedy is no less awful, but one instinctively suspects that things will somehow change. When one is at mid-life, tragedy is more likely to be experienced as permanent. A divorce, the loss of one's health, of one's child, or of one's hope of someday having children—all of these crises make it hard to imagine a future which is different, changing and developing. One feels compelled instead to imagine the future as more and more of the same. This tends in turn to reinforce old fantasies of finding perfection and happiness by remaining an early mother.

The resolution of this crisis comes only with time and effort. There are, however, a number of strategies one can employ to help the process along. On the professional level, one has to keep growing. For those of us who are in direct service, particularly for those of us who make home visits, this means finding ways to counteract the isolation which such work tends to create. It means finding other people with whom we can share our work in a context which offers, not just emotional support, but also the opportunity to learn new and better ways to do what we do. The cure for the "professional early mother" syndrome is to become more *professional*, and that almost always entails becoming more intimately connected with other professionals.

On the personal level, resolution means coming to terms with one's inner beliefs about motherhood and perfection. The early mother is not the perfect mother; she is simply the appropriate mother for a certain period of development. Resolution also involves the process of capturing and appropriating the positive memories of one's own childhood and of one's own later mother. This should gradually result in a clearer awareness of how one's mother and oneself, while far from perfect, nevertheless possessed many strengths together, for how else could one have survived and thrived as well as one has? Furthermore, resolution involves incorporating a new vision of the future as extending into an unknown in which change and development are still possible. Finally, it involves listening to one's family and friends who are so frequently reminding one that there is more to life than motherhood, that children after all grow up to have their own lives, and sometimes the best way to show them how to do that is to make sure one has a life of one's own.

IV. The Crisis of Confidence

The maturing infant mental health specialist one day arrives at that point in life when her gray hairs outnumber all the others and her colleagues begin to look up to her as though she were somehow wise. Having arrived at this prestigious plateau, she may find that her parenting tasks have shifted somewhat. Her children may be grown, away at school, or starting families of their own. Her career has developed to the point where she now administers a program, supervises other clinicians, teaches students, or serves on various policy-making bodies. She is beginning to parent "at one remove."

Some infant health specialists who are experiencing a crisis of confidence may seem grief-stricken and angry, overwhelmed by today's social problems. Others may speak unrealistically of infant mental health as a panacea for most human ills.

This can be a very rewarding time, for it allows her the luxury of some distance from the daily fray, and gives her a vantage from which she can survey the field with a broader perspective. All of this helps her to find a better sense of balance about her work. Her years of experience, both with her cases and with her own family, help her to normalize the various situations she encounters. That is, she is more able to perceive the positive along with the pathological aspects of real life situations. She can more easily see her families and their infants not just as vessels of human loss and misery, but as the marvelous testaments to human adaptability that they often are.

This is not to say there are no problems. Some of these may show up in the older infant mental health specialist's remaining clinical work. By this time, she is probably quite skillful in the conduct of her casework. She is calmly self-assured about her own maternal capacities, she is gently supportive of the young client-mother's dignity, yet she is unafraid to speak plainly when necessary. She would seem the nearly perfect clinician. It is somewhat surprising therefore that such a superb clinician should sometimes carry a caseload comprised almost entirely of families whom she has known for a very long time. Many times these are families whose babies are now preschoolers who play in another room while she visits with the mothers.

The intervention offered is often quite spectacular, but it is no longer infant mental health work.

This raises the sometimes difficult questions of how to distinguish between cases continued because further work is necessary, and cases continued because the specialist is having some inner difficulty terminating the case. It would seem that the answer often hinges upon a realistic assessment of the developmental status of the children. Sometimes it happens that the children seem to be doing well, yet their good development does not quite manage to assuage the specialist's worries about the families' ability to "maintain" the gains of treatment. Sometimes the specialist seems much more aware of her clients' liabilities than she is of their competencies. Whenever this is the case, one may fairly wonder whether the hesitation to end the work is the specialist's more so than the client's.

The crisis of confidence can also manifest itself in her administrative and educational work. Here it usually assumes of of two forms. In the first, a sense of global discouragement creeps into the specialist's manner. She may talk a lot about today's overwhelming social problems—drugs, poverty, teen-age pregnancy—as though there were no possible hope of solution. She may carry about a heavy burden of grief that rarely seems to lift. She may appear chronically angry at the institutions and professions which share responsibility for children and mothers.

On the other hand, one sometimes encounters the mature specialist who, once she leaves the direct clinical work, becomes an unrealistic visionary. She may begin to speak of infant mental health as though it were a panacea, able to cure most human ills—cheaply. At the same time, she may seem inordinately suspicious about new ideas and approaches. When she writes up her program or one of her cases, everything may become so simple and so successful that her students (and often colleagues) begin to shudder at the prospect of living up to her claims.

Both of these apparently antithethical sets of behaviors imply a certain crisis of confidence in the outcome of one's maternal efforts. The first worker seems to feel that none of her clients or programs or methods are strong enough to survive on their own. Her sense of being indispensible really seems a cover for her uncertainties about her professional offspring. The second worker seems to share this sense of insecurity, but attempts to mask it behind her denials. Returning once more to the series of fantasies about motherhood and perfection which I have been pursuing throughout this paper, it is as though these specialists are saying: "All my children must be perfect, because only by producing perfect children can I avoid utter failure as a mother."

By now it should be obvious that the series of fantasies I have been describing throughout this paper are all variations on a common theme. In one way or another, they all have to do with the search for perfection. The developmental crises we have been describing are related to this search, to the illusion that is can be successful, and to motherhood as one major arena in which this illusion must be surrendered. It seems likely that all individuals are called upon to wrestle with this problem. Everyone must in some way learn to give up the belief in one's own perfection, whether it is couched in a belief about one's perfect parents, one's perfect self, or one's perfect offspring. The problem for the infant mental health specialist is that she is called upon to do this in the midst of the continual celebration of life's renewal that defines infancy.

Everyone must in some way learn to give up the belief in one's own perfection, whether it is couched in a belief about one's perfect parents, one's perfect self, or one's perfect offspring.

The infant literally begs us to believe that everything is possible. The magic of giving birth, of holding that tiny being to our cheek and *feeling* its breath, motion and warmth, is a momentary epiphany of something greater than ourselves breaking through the veil of everyday existence. Watch next time you attend a funeral. Watch what people do as they return to the family home. Especially watch what the old people do. They turn to the babies, for the babies are the guarantors of our belief that death shall not prevail over life.

This magic is necessary, helpful and good. Infant mental health work in particular is the beneficiary of this biological gesture of kindness, and those of us who do this work know just how dependent we are on that magical surge of hopefulness within the heart of even the most hardened client-mother. But it is dangerous to live continuously under its spell. And it is positively disastrous to allow oneself the illusion that one is its permanent dispenser.

Spending one's professional life within this delicate and magical space is not an easy task. It calls for humility, selflessness, professionalism, and a willingness to surrender to the inevitability of life. The reward, however, can be the realization that as one has struggled through each of these crises one has also grown personally, that one's professional work has left one calmer, warmer, more honest and wise.

The Supervisory Relationship: Integrator, Resource, and Guide

by

Rebecca Shahmoon Shanok

The best supervisors I've had—and there need to be many over the course of a career—listened intently, found something to value, and then recast what I told them, embellishing it with something of their own. The experience of good supervision is like finding a fellow-traveler on a challenging journey, a companion worthy of trust who has visited similar destinations. This fellow traveler knows many routes to our goal but is open to discovering a different path, a path we walk together, often with me in the lead, except when I miss the flowers to smell, or when I stumble or can't find my way. Then the supervisor is there to guide, even to prod a little, to bolster my courage, and to help me regain my footing and focus, to help me find my strength.

Supervisor: *"Tell me what you did, and how you felt about what you did."*

When it's going well, supervision is a holding environment, a place to feel secure enough to expose insecurities, mistakes, questions, and differences. Supervision parallels good work with families, the place for parents and children to feel safe enough to recognize the worst and best of their feelings and capabilities with a partner who helps them get where they need to go.

Good supervision makes the supervisee long for more. She feels, "If only I could tell my supervisor every single thing that happened in the interaction, I would feel more secure and know what to do." Of course, this is never possible, and, in fact, reminds us of the frustration that is an integral part of "good enough" mothering. "Good enough" supervision cannot review everything that *has* happened, nor can it anticipate everything that *might* happen.

The supervisory relationship represents an investment on both sides, a cooperative enterprise, a comradeship. To understand its power and value, it is useful to look at what the supervisee and supervisor each bring to the relationship, and at the ways learning takes place within it.

The supervisee

In her daily work with infants, toddlers, and their families, the supervisee is on the spot. She must make a multitude of moves in the given situation. "Out there" in the situation, she learns by doing; in supervision, she learns by reflection.

Initially, the supervisee focuses on and reports behaviors and actions. She may give verbal summaries to her supervisor, basing her reports on memory, notes written after a treatment session, or notes written during a session. She may use process recording, a method of attempting, after a session, to record every nuance of both the client's behavior and apparent feeling state her own, and the interaction between them. Both approaches encourage the supervisee to become more adept at reporting, a skill which is fundamental to the ability to reflect on process and, eventually, to introspect about it. Moreover, with the help of animated yet gentle inquiry by the supervisor, the supervisee increasingly observes and reports on her functioning in relation to feelings, and gradually in relationship to complex feeling states as they are responsive to her patients ... and a her patients may be reacting to hers. She becomes able to consider thematic connections between patterns in her own key life relationships and the evolving relationships with her clients (Greenspan & Wieder, 1984). She comes to know herself in the work, to recognize herself as an instrument, learning which vibrations are likely to be emanating from the patient and which, though stimulated by the patient, are in fact refrains from her own inner melodies.

Front line work with very young children and families is an intense experience—always challenging, sometimes joyful, many times humbling. To metabolize these experiences fully, the practitioner requires a confidante—someone with whom to focus, investigate, and brainstorm; someone with whom to share the experiences and the reactions; someone to be a model and to mirror the emerging professional self. Every practitioner has had uniquely painful experiences, and each tends to keep some things hidden. How much a given supervisee feels she has to keep hidden and how

---

Supervisor: *"What I think that I hear, Jean, is that whenever the Mom begins to talk about her feelings of being trapped by having such a needy child, you tend to move away. Let me tell you what that suggests to me and then you can think it over and see what occurs to you. Okay?"*

---

much she lets the supervisor see depends greatly on her sense of being partnered, her sense of safety in the supervisory relationship. In a good one, the supervisee feels understood, recognized and respected. She is thus able to feel enabled, rather than undermined, when the supervisor offers information or raises questions and concerns. The supervisee feels that the supervisor is on her team.

The supervisor

The supervisor is an expert because she was a front line worker. She was there. She saw it, felt it. By now, the supervisor can also bring a conceptual framework, experience, and a process of inquiry to the task of finding a way of working with a particular family and child. With supervisees, she hunts for strengths to support and cultivates a sense of optimism about the supervisee and about the work. She plays midwife to the emergence of the trainee's own strength and style.

The supervisor is a teacher who fosters the integration of process and content learning. But unlike classroom instruction, which can be planned systematically in terms of content and objectives, supervision is more like a life-space, spontaneous interview. In this context, the supervisor may relate theory to practice, teach a theoretical point, make a connection, appreciate what the supervisee did, tell a story to illustrate a point, share an experience or feeling, ask questions, point out a pattern, or raise a concern (Sheafor & Jenkins (1982); or she may simply listen, validating, even cherishing the supervisee's experiences. She also helps the supervisee to maintain continuity of attention, so that concerns and strands of interest are developed rather than lost.

Supervisor: (To the supervisee who seemed to have withdrawn with a family who was furious about a glitch in the services they were supposed to receive): *"That must have been* **really** *hard to take. They remind me of a father who cursed me out at the top of his lungs when I told him I had missed sending out an insurance reimbursement form. And this situation wasn't even in your hands. What did it feel like to you? And what did you* **do***? And, then, what happened?"*

The supervisor models openness and good practice. She is willing to say, you can relax here and let the picture build. But here where there is danger, we must decide on an intervention. And here where there is opportunity, let us move forward.

Like any other good clinician, a supervisor develops a sixth sense about how others are feeling. She has an ability, often preconscious, to place herself in another's space, to imagine how he feels. But every once in awhile she checks it out: "I think you are letting me know that .... tell me, did I catch it correctly?" Thus she shares what she sees/feels, enlisting the supervisee as co-adventurer, indeed as expert on her dawning self recognition. And within such colleagueship, self-recognition, plus knowledge, plus skill equals self-as-instrument, self-as-observer, self-as assessor, self-as-intervenor, self-as-clinician.

The supervisor is open to honest feedback from students and workers and is willing to be led by them when appropriate. Supervising democratically means knowing when and where to ask for help. Like a "good enough" mother, the supervisor needs to figure out what she needs to avoid becoming overwhelmed—companionship, peers to talk with, time to think.

The supervisory relationship

A supervisor and a supervisee are not unlike Sherlock Holmes and Dr. Watson, the senior partner more a thinker and the junior more a doer, but each essential to the other. Curious and motivated to solve a problem,

JANET BROWN MCCRACKEN

they hunt for clues to guide their understanding of how best to offer services to a distinctive family and their unique child. Through their exchanges, supervisor and supervisee develop a mutual formulation as they strive to understand what is going on with children and families in their care. Neither one could do the work alone.

Each keeps the balance of the other. For example, work with children and families often involves going beyond our personal comfort zone in the making of relationships. Making relationships across classes and cultures, or with people who have been wounded and who cannot join reciprocally, who cannot give us the feedback that would let us know that we are doing all right, requires the insight, courage, and resilience born of collaboration.

The supervisory relationship is about power, but it does not need to be about dominance or control. Any supervisee recognizes her supervisor as someone with power over her. The greater the felt power, the greater will be the supervisee's anxiety. As much as possible, then, the power needs to be transferred. In the relationship model described here, the power is shared (which is a great relief not only to the supervisee but also to the supervisor!). The supervisor facilitates the articulation of a contract, even as she helps supervisees make explicit their contracts with families. The supervisee needs to have the right to:

- participate in developing the learning structure to which she is being exposed;
- develop a contract or an agenda defining reciprocal expectations;
- take first responsibility in analyzing her own work; and
- contribute meaningfully to her own evaluation.

In doing these things, the student/supervisee develops her capacities for reflection, analysis, and planfulness. She becomes more responsible and is better able to think and contribute creatively to her own learning when she has had a stake in developing the terrain to be covered, when the qualities of the learning are explicit, and when the supervisory relationship features openness (Manis, 1979).

For her part, the supervisor depends on the supervisee's ability to observe, interact, and report. She acknowledges—even respects—the supervisee's style and choices. The "good enough" supervisor recognizes that there are many roads to Rome and that her supervisee will come up with a novel, yet authentic and meaningful response in a given situation. The supervisor seeks and supports that which is facilitative in the supervisee's work. She also raises questions about those areas of the supervisee's interactions and functioning which reflect either blind spots, limited knowledge, or lack of experience, confidence, or awareness. The supportive supervisor violates the supervisee's negative expectations, just as the supervisee will try over and over again to violate the negative expectations of those families too wounded by past experience to enter the therapeutic relationship with optimism. People learn and grow when they feel understood, supported, and, when appropriate, even appreciated. There is an exquisitely delicate relationship between the experience of positive regard, self-esteem, and the ability to be effective.

Supervisor: (Earnestly) *"If we realize that you were only at the center for two hours last week, it's easy to see why your observations are so sketchy at this point. It's just not possible to do an adequate job in such a short time. You'll recall that the application materials state that ten hours per week at the Center is required. What else are you trying to juggle?"*

Thoughtful supervision is a process through which the supervisee comes to recognize the decision points in a given case and the basis upon which to make decisions. But "decisions" are not to be seen as "answers" (or worse, *the* answer). Rather, decisions represent a forward position, a choice of direction along a path that will yield further useful information and another decision point. In-depth supervision looks beyond decisions and beneath manifest details of behavior, interactions and learning styles. The trust and safety of the process encourages peering below the surface to latent ideas and *feelings* of clients, of the supervisee, and, at times, even of the supervisor. By recognizing and engaging with the supervisee around the emotions they are experiencing, the supervisor models the use of empathy and the recognition and use of emotional experience in professional situations.

To understand feelings, it is important to attend to the history and context of *each* individual involved; people get to know each other in supervision that is going well. (Attention to what lies beneath the surface should not distract us, however, from appreciating what might be taken for granted. Sally Provence has talked about using common opportunities to facilitate learning, and how supervision can assist a practitioner in recognizing the value of her daily work. People do not always appreciate the tremendous power of concentrated listening, for example, or the importance of "merely" playing with a baby, helping a baby be aware of you and the exchange when doing something as mundane as changing a diaper.)

Monitoring and evaluation are part of the supervisory relationship, but because the monitoring or evaluative aspects are built in, the supervisee always knows where she stands. Strengths are emphasized while vulnerabilities are partnered. Depending on the styles of both the supervisor and supervisee, the relationship may be informal or relatively formal. There is always, however, a fostering of deep respect for observation of others and of self. Such painstaking observation sponsors the capacity for introspection. To teach introspection requires that the supervisor use an appropriate level of self disclosure to alleviate unproductive anxiety of the supervisee and model, as well, thoughtful self-evaluation.

Special issues in supervising work with infants, toddlers and their families

Supervision in infant-toddler-family practice is particularly challenging because so much of what we sense and of what we communicate occurs without words, most obviously with the children. While we tend to think of supervision as a verbal medium, it is worth dwelling for a moment on the non-verbal aspects of the process. Expressive and gestural communication, patterns of mutual gazing and turn-taking, and body language convey much. When patients do not yet use words, supervisees are challenged to notice and to report on behaviors and expressive nuances that they take in through the range of their own senses (good practice even for work with highly verbal people). As Stanley Greenspan (1989) notes, "the basic emotional messages of life, safety and security versus danger, acceptance versus rejection, approval versus disapproval, are all communicated through facial expressions, body posture movement patterns, and vocal tone and rhythm. Words enhance these most basic communications, but . . . we all form split-second judgments (about) a new person . . . before the conversation even gets started." It is worth asking what, without the use of words, will help a particular individual feel accepted, safe, and understood in supervision; so, too, in treatment.

Another challenge in working with infants, toddlers, and their families involves the "continuum of identifications from baby to parent" (Bertacchi & Coplon, 1989) represented by the very different professions that

work with this population. Reflecting on the differences in training emphasis in, say, social work or early childhood education (to say nothing of the different personal experiences and proclivities which incline an individual to select one or the other field in the first place), one can see how one professional may more easily identify with the parent, the other more easily with the child. Supervision can be the place to recognize such positions and to motivate change toward the ability to mix identifications, see from many perspectives at once, and plan interventions that will work for *families*, rather than only for an individual parent or child. As Bertacchi and Coplon point out, the internal shifts necessary for good dyadic and family work do not diminish the unique insights and talents that individual professionals use themselves and share with team members. Similarly, the great value of receiving supervision from individuals trained in other disciplines complements, but does not replace, the importance to one's professional identification and maturation of enjoying the supervision and leadership of someone trained in one's own discipline.

Supervisor: (Smiles) *"Okay. It's time for us to do your formal evaluation. I'll just sum up what we've been talking about all along. Here's what I see as your strengths ... And these are the areas to work on ... Tell me what you think of what I've said, and if it makes sense to you, how do* **you** *think we could work on those areas?"*

As we think of supervision in the overall context of training people to work effectively with infants, toddlers, and their families, it is worth pondering about how adults develop, change, and grow. Let us reflect on our own histories and present experiences as learners and as leaders. The intertwining of theory and practice implies a process. We are deeply aware of the tension between the process-oriented approach to training, which seems to take close to forever, and a didactic "cookbook" approach, which obviously cannot do the job. The analogies and parallels between training and practice in the infant/family field provide us with fortunate synchronicity and coherence among what we know, what we believe, what we value, and what we do.

But there is also an unfortunate side, because our training approaches cannot be mass produced. Relationship is a very special subset of experiential learning. When we recall the enormous contributions to education of John Dewey, father of experiential learning, or the long history across cultures and fields, of apprenticeship, or in fact, when we remember how babies learn to become mothers or fathers, we recognize that student workers fully need activity and reflection to become integrated; they need to be "brought up" in their fields and in the zero to three concentration. Jeree Pawl has said, "Supervision is a safe place, where the generosity which is shared with a supervisee can then be passed on to families and to children." It is an oasis where new practitioners can stumble and can stride, be refueled, and then go off to do their work once again. The supervisee moves forward carrying within herself self-respect, a sense of responsibility, and knowledge internalized through meaningful relationship.

Experiential learning and relationships demand risk-taking. They foster coping, adaptation, and mastery. Through the myriad transactions of supervisory relationships, the supervisee changes and grows. Her new capacities move from what has been called "the domain of the new and 'tacked-on' to the domain of the familiar and indispensable" (Pine, 1985). Change occurs in self-image, in behavior, and the way she is viewed by others. The supervisee develops an expanded and more resourceful sense of self, including self as observer, self as intervener, self as committed to zero-to threes and their families, self as not necessarily knowing the answers, but as being able to figure out the next step—*collaboratively.*

References

Bertacchi, J and Coplon, J (1989). The professional use of self in prevention. *Zero to Three*, Vol. IX, No. 4, p. 6.

Greenspan, SI (1989). *The Development of the Ego.* Madison, CT: International Universities Press, p. 132.

Greenspan, SI and Wieder, S (1984). Dimensions and levels of the therapeutic process. *Psychotherapy* Vol. 21, Spring, #1, p. 7.

Manis, F (1979). *Openness in Social Work Field Instruction.* Goleta,CA: Kimberly Press, Inc.

Pine, F (1985). *Developmental Theory and Clinical Process.* New Haven, CT: Yale University Press, p. 120.

Sheafor, B and Jenkins, L (1982) *Quality Field Instruction in Social Work.* NY: Longman, p. 64.

Call for abstracts:

A conference entitled "International Child Day Care Health: Science, Prevention, and Practice" will be held in Atlanta Georgia on June 15-17, 1992. Submissions are encouraged for concurrent scientific sessions on infectious diseases; injuries and hazards; health promotion; children with special needs and disabilities; environmental health; developmental and psychological aspects; occupational health; impact of regulations, standards, accreditation, and training; and economics. **The abstract deadline is January 15, 1992.** For information, contact Lillian Glickman at Pace Enterprises, Inc., tel: (404) 633-8610; FAX (404) 633-8745.

Scenes from Supervision

by

Judith Pekarsky
Infant-Parent Program
San Francisco General Hospital, University of California at San Francisco

It is sometimes easiest to see the importance of supervision in rather intense, troubling situations where work with a young child and parents is clearly faltering. Such was the case when a trainee at our program walked into my office for supervision one day after several months of difficult meetings with a family, and announced firmly, "I'm not going back there." Her jaw was set, her tone challenging but resolute, and I believed her. I also recognized that this conscientious, dedicated woman must be feeling a great deal of distress to make such a pronouncement. I knew several other things, as well: that frustration and anger at families are common in this work, and that no one can do any kind of useful work with an infant, toddler, or parent while overwhelmingly in the grip of such strong negative feelings. I said to my supervisee that I was certainly not going to *make* her go back to see the family, that that could hardly do anyone any good, and then I asked her to tell me what was going on. We needed to understand this situation together and then we could figure out what needed to happen. The trainee was visibly relieved, sat down, and began talking. I listened.

This woman, Sheila, was a pre-doctoral student in clinical psychology who came to our infant mental health program for training in psychotherapy aimed at improving the relationship between infants or toddlers and their parents. The case we worked on together (she as therapist, I as supervisor) involved a little boy who had been removed from the care of his single mother at birth because of her history of serious emotional difficulties and acting out against an older child, now living with relatives. The little boy had returned to live with his mother at 23 months of age after relatively little contact with her. The reunification had not gone smoothly for mother or child, and while the mother did not physically hurt her toddler, she treated him in increasingly controlling and demeaning ways. During weekly home visits with mother and child, the trainee had witnessed many instances of such harsh treatment, but had rarely felt effective in her interventions with the mother. Her remarks, questions, and even her silence were frequently discounted.

As Sheila sat down to talk about why she was refusing to work with the family further, several issues in this complex situation became evident. Some of them we discussed; only a few will be noted here. Sheila explained she was sure that this mother could not be worked with, and she recounted the many exchanges in which her client had been unresponsive or dismissing of her efforts. We discussed how stymied she had felt, particularly when she watched the toddler being so badly treated. It was clear to me that Sheila's concern for and identification with this little boy, coupled with her frustrating inability to improve matters, had made her increasingly impatient with and angry at the mother. She had intensified attempts to explain the child's behavior to the mother and to suggest alternative ways of dealing with him. What had suffered in this process was her empathy with the mother's experience; efforts to understand her and the sources of her behavior had dwindled.

While Sheila and I had discussed her frustration in numerous supervision sessions, this time I understood the situation differently. It seemed to me that I had never sufficiently recognized how awful it felt to Sheila to see this family. I had certainly listened to and acknowledged her concerns, but I always moved on to discussions of the mother and her feelings about her child, as well as ways to intervene around their interactions. Clearly, as I had pushed Sheila to empathize with her client, she had pushed the mother to empathize with her toddler. No one's feelings had been truly seen as important.

In the course of our conversation, I said to Sheila that I thought she had been telling me for some time how awful this case was and I had not really listened. Her tone shifted to one less challenging and more pensive. She began to talk about what had gone wrong in the intervention and why. She thought about the child, the reunification, and finally, about the mother. After an hour, we agreed to consider alternatives to Sheila's seeing the family, and Sheila volunteered that she would think further about the whole situation. For our next meeting, Sheila arrived looking more relaxed and composed, and calmly determined. She announced that she did want to try to work with this mother and child. She added how important it was that I had "respected her judgment that the mother could not be worked with" and had told her she "didn't have to". Later, she explained that she could then "be curious about what was going on." I had been fully prepared to discuss a plan for ending her work with the family and transferring the case to another therapist if the mother wished to do this; however, I was certainly supportive of Sheila's decision to continue, and we discussed what Sheila thought about future sessions.

The subsequent course of the work was not without difficulties, but a major shift occurred; the supervisee began to think about the mother's experience and could readily see things from her perspective. As this happened, Sheila stopped pushing her client toward particular ways of understanding and treating her son, and her client controlled the toddler much less demandingly and harshly. Months later, at the end of their work together, the mother thanked Sheila for her concern and for providing "just the thing we needed."

Most often the usefulness of supervision is embedded in quite ordinary exchanges between supervisee and supervisor. Discussions about what went on in a meeting with the family, who did and said what and in response

to what, what did *not* happen, and possible reasons for all of this are the routine in supervisory sessions. Taking this time to think seriously about the status of the work regularly produces expanded understanding and new ideas about needed directions, as well as recognition of potentially troubling issues between clinician and family. What has been overlooked or incompletely understood by the clinician can be identified—whether by the supervisor, the supervisee, or mutually and interactively. This is what supports good work with young children and their families.

Recently a seasoned trainee in our program answered my query about why the report by the mother of a toddler's considerable distress in childcare had not been explored in a session; she said thoughtfully, "Well, I don't think I wanted to talk about Tina's behavior" with the mother. We both knew that this avoidance needed to be understood. My supervisee, Ellen, had been seeing this mother-child dyad for months. The family had come to the program because the child's response to even relatively brief separations from her mother had been inconsolable, prolonged high-pitched screaming. Ellen's assessment of the situation suggested that the difficulty around separation was reltaed to the mother's complex reluctance to leave her child; this stemmed, generally, from her sense that only if she utterly sacrificed her own needs and wishes would she be a good mother.

Initial sessions had included discussions of the feelings mother and child experienced during separations and concrete ways to help both cope with these. The separation difficulty resolved, and the work then focused on other problems in the mother-child relationship and the mother's life, most of which were also reflections of her difficulty balancing her needs with those of others. After many months the mother was able to make a decision to resume her education by taking a few courses, which necessitated enrolling her daughter in partial-day childcare several times a week. Following the first week of school, the mother had spoken compellingly of her own experiences and concerns about classes, and in passing had mentioned her toddler's crying during mornings at childcare.

During our next supervision meeting Ellen had similarly been full of accounts of the changes in the mother's life and the reasons for and ramifications of these. A careful reporter, she also noted the little girl's response to childcare. Ellen and I spent some time discussing the mother, and no further mention was made of the problem Tina seemed to be having. I remained mindful of the initial mother-child difficulty and our efforts to support the child's functioning, however, and later in our supervision session, I inquired about the details of the toddler's upset in childcare. Startled, Ellen replied that she actually knew nothing about this. The mother had not volunteered anything, and she had not asked. It was at this point that Ellen stated she had not wanted to talk about Tina's behavior. She then began to reflect on her disinclination to pursue a discussion of the toddler's difficulties—explaining, "I guess I didn't want to make her mother feel more guilty." Ellen was readily able to see that she feared any focus on Tina's reaction would have exacerbated the mother's guilt at leaving her daughter in order to pursue her own wishes.

FAITH BOWLUS

Together we decided that the mother's inattention to Tina's behavior already reflected discomfort with the decision she had made about school, and Ellen realized that she had joined the mother in avoiding the subject. I wondered whether the clinician's silence might have felt to the mother like a confirmation of her worst fears: that in leaving Tina, she had done something too bad to talk about. Ellen certainly did not feel this way, and she recognized that discussing the toddler's difficulties and the mother's feelings would in fact be helpful both in tempering the mother's guilt and in permitting her to help Tina with the separation. Whatever the possibly complex reasons for Tina's distress, the situation needed to be explored so as to arrive at ways to help the child. In the next session with mother and toddler, Ellen pursued the opportunities to discuss Tina's crying in childcare. This was an obvious relief to the mother, who quickly conceived an appropriate approach to the problem and went on to reflect further on her worry about doing things for herself. The clinician reiterated their conclusion of months before that she could do things both for herself and for Tina—though it was not always easy to balance these efforts—and therapist and client agreed to keep thinking about this issue.

Supervision as a Catalyst in the Evolution of an Integrated Infant Mental Health/Developmental Intervention Program

by

Barbara Ivins, Ph.D. and Nancy Sweet, M.A.
Child Development Center, Children's Hospital
Oakland, California

The Parent-Infant Program at Children's Hospital in Oakland, California is a parent participation program that serves an exceptionally diverse group of families with developmentally disabled and at-risk infants in Oakland and the urban eastern Bay Area of northern California. Our commitment to providing and developing new services for this population has been longstanding. We emphasize both direct service to individual babies and families and involvement in the development of local, regional and state early intervention policies.

We have become passionate proponents of a service model that fully integrates mental health and developmental interventions for infants and families. The evolution of this approach has been gradual, but unswerving in its direction, as our program has grown from a staff of three serving 16 families in 1977 to a staff of 15 working with 100 families in 1991. Clinical supervision has proved to be extremely important in the development of our program. Looking back over almost 15 years, we realize that the status of supervision at any point in our program's history says a good deal about our program's overall development at that time. We can also see that clinical supervision has served as an important catalyst for change in the ongoing development of our program.

In the pages that follow, we offer a natural history of our program and approach. We will pay special attention to the role that clinical supervision has played, and continues to play, in helping our program to offer more effective support to infants and families.

Stage One: Parent education and support

The first early intervention program in the Child Development Center (CDC) of Children's Hospital, Oakland, began in 1977 with a model demonstration grant from the U.S. Department of Education. Since one of the senior CDC staff who developed the proposal had studied with attachment theorist John Bowlby, the Parent-Infant Program focused from its very beginning on supporting early family relationships as well as ameliorating the impact of the baby's developmental problems.

In the home-based Parent-Infant Program, the interventionist was a developmental and behavioral consultant for the family. Through weekly home visiting, this primary intervenor developed a strong relationship with each family. Our home-based model promoted a transdisciplinary approach. The program's first generic "infant development specialists" had backgrounds in special education and early childhood education; later, people with backgrounds in developmental psychology, occupational therapy, speech therapy, and nursing joined the staff. Center-based programs for groups of parents and infants were added to complement home-based services.

The program was small, and the supervisory model was intentionally one of collegial support. Staff members acted as a supportive "family" for one another; this enhanced their ability to be supportive, in turn, to the families with whom they worked, often in the (professional) isolation of the family home. Staff cohesion stayed strong in the face of unstable funding, limited facilities, and the emotional demands involved in supporting families who were confronting the newly diagnosed disabilities of their babies.

Our conception of "work with families" changed with experience. A service model that called for parent participation in every aspect of the program resulted in opportunities to work with caring, articulate, committed parents, whose diversity and capacity for coping we learned to respect enormously. The notion of "educating" parents about the needs of their babies changed very quickly to a model of *supporting* parents, as they went through the process of adjustment to a vulnerable baby or a baby with disabilities.

From the beginning of the Parent-Infant Program, our experienced social worker provided marital and crisis counseling for families and support for the intervention staff. We also began parent support groups. Still, there were families with whom we felt our interventions failed. Acute and chronic mental illness, child abuse and neglect, family violence, and the combined impact of multiple problems challenged our staff's skills. If we referred these families to more child-centered early intervention programs, we felt uncomfortable: We knew that respite might be beneficial for the parents, but we also knew that significant family relationship problems would not be addressed. We looked for a new approach.

Stage II: Specialized mental health intervention program

In 1983, a second model demonstration grant enabled us to develop a special program for "double jeopardy" infants—babies who were both biologically and psychosocially at risk. When we recognized attachment problems or other parental risk factors in families of developmentally disabled or delayed infants who came to the Parent-Infant Program, we assigned a clinical psychologist as the primary intervenor with the family. She provided intensive mental health interventions, working with an infant development specialist and the staff clinical social worker as a supportive team. This was our first opportunity to blend infant mental health and developmental intervention approaches.

Grant support also enabled us to begin a training program for all early intervention staff in infant mental health concepts, attachment theory, family systems theory, and interaction observation techniques (Bowlby, 1969; Bromwich, 1981; Greenspan, 1981; Provence, 1983).

We expanded our common thinking about how to work with parents and infants and blended ideas from our diverse professional backgrounds. The clinical psychologist led multidisciplinary clinical supervision with staff, but these opportunities could only be used in relation to infants included in the "double jeopardy" demonstration project. Meanwhile, the developmental staff began to meet weekly in the early morning before the Center opened, to continue to provide collegial support and discuss developmental concerns about infants and families who were not in the project.

This demonstration program achieved very positive outcomes for infants and families, but proved to be a stressful model for staff. At this stage in our program's development, we were struggling to address both the psychological needs of parents and the developmental needs of infants by integrating the perspectives and intervention approaches of infant mental health, child development, and social work. Sometimes, however, we seemed to be offering three parallel interventions with mental health intervention the new and dominant intervention for most families. To the extent that staff struggled for control over the intervention with a family, we lost the potential power of a truly transdisciplinary effort.

Stage III: Growing pains and a growth spurt—toward integrated services and supervision

In 1986, foundation funding allowed us to hire a full-time clinical psychologist to provide infant mental health services and staff support. While the psychologist who had worked with us previously worked only part-time in our program, the new clinical psychologist became a fully integrated member of our staff.

The clinical psychologist's first task was to understand the scope of the Parent-Infant Program and the ways in which she could use her skills to support staff and families most effectively. She had expected initially that colleagues would want to refer multiple-problem families to her for direct clinical intervention. This was not always the case. Instead, the psychologist found that other staff members came to her when they found it hard to be the only professional working with a family. Sometimes parents were depressed or actively grieving; sometimes questions of infant parent attachment were troubling; sometimes multiple and complex needs seemed to be overwhelming both families and staff. Staff tended to feel that they should be always available to families and somehow "responsible for everything." Not surprisingly, they often experienced an acute sense of failure.

Much of the pressure on staff could be traced to changes in the external milieu surrounding our program in the mid-1980s. Family needs were becoming more acute, but societal resources were shrinking. The crack cocaine epidemic began in earnest. More and more families referred to the program had multiple problems. More of their babies had been born prematurely; more were medically fragile; more lived in single-parent families, or in households whose members spoke no English. More families needed help with housing, respite, and basic communication with other therapists and medical staff.

At the same time, the steady pressure toward program growth had resulted in a larger, more diverse early intervention staff. Challenged to serve such complex children and families, we felt increasing confusion and discomfort about professional roles, appropriate interventions, and the limits to our services. Many developmental specialists felt that their own training and experience were not being used, while they were being expected to take on unfamiliar roles as social worker, case manager, or provider of emotional support to families. Staff discussions began to focus on the discrepancies between what we thought we were providing to children and families and what we actually were providing. We were going through our own growing pains.

We had no regular staff supervision at this time. All staff members spent most of their time in one form or another of direct service to families, who participated in varying combinations of center-based group activities, a parent support group, in-home developmental intervention, counseling, or infant-parent psychotherapy. Three or more staff members might have weekly contact with a family, but contact with each other would be limited to brief conversations. Only one hour a week was available when the whole staff could meet together to discuss "problem cases" in a program that now served up to 70 families at any one time.

Taking care of ourselves: Implementing supervision

There were many reasons why we "couldn't possibly" establish an organized, regular system of clinical discussions among staff. Once demonstration projects that had included opportunities for communication, training, and supervision as core elements of a good program were completed, we faced the harsh realities of state and local reimbursement for direct client contact only. To survive financially, we carried higher than optimal caseloads. We could not get reimbursed for time spent making chart notes, formulating developmental plans, writing reports, consulting, or discussing cases. Case discussion disappeared, and in this context the idea of an organized case review felt more like an extra burden than like help. Staff were frustrated and ambivalent—we wanted to talk about cases, but felt that there was no time.

Another barrier to regularizing supervision may have been our unwillingness to acknowledge the implications of our own growth. Key staff kept their sense of the program as it had been when everyone on staff knew all the families in the program, and when collegial interaction and support were part of our daily working lives. Our desire to remain the small, intimate program we had been was at odds with the reality of the larger and more diverse program we had become.

Fortunately, we were able to take three steps toward positive change:

- **We produced a one-page philosophy statement.** After what seemed to be agonizing months of weekly discussion, we found a way to describe in four sentences what we were trying to do with families and what our version of early intervention meant. We said,

We believe that the family is the most important influence in the development of an infant and therefore seek the active participation of family members in our program. We are committed to promoting healthy parent child relationships that balance the needs of parents with those of children and the whole family. The Parent Infant Program (PIP) recognizes the wide range of needs and complex feelings experienced by families with infants who have special needs and offers support in facing stress, uncertainty and often difficult decisions. In helping families to understand and accept the strengths, limitations and developmental potential of their child, and in providing a safe place to share concerns with others, we hope that parents will become better advocates for their child and feel more satisfied, confident and competent.

We could give this statement to families at intake to help clarify for them what our program stood for. We could use this statement, which crossed disciplinary boundaries, to define our own role with families in a new way. Now we felt freer to provide a more flexible intervention to families, based on assessment and need rather than dictated by requirements of funding sources or shaped by the training paradigm of a single professional discipline. Now it felt legitimate to consider a more integrated approach to developmental, educational, emotionally supportive, and relationship-promoting interventions. When we followed the principles of our philosophy statement, we felt that we were "doing the job"—the job that we had defined together, that we had given ourselves permission to do.

- **Simultaneously, we established a weekly supervisory hour for each home visiting infant specialist.** Because of our continuing concern about possible fragmentation of the various home- and center-based services that families used in our program, we designed a model for supervision specifically to reflect our model of service delivery. Each infant specialist began to meet weekly in a group that included the clinical psychologist (who had now been designated as Director of Clinical Services for the program), the program's clinical social worker (who saw all families at intake and also facilitated parent support groups), and the center program coordinator (who was the one staff member who saw all of the children and families in the center-based portion of our intervention program.) Since the discussion in each such meeting flows from the infant specialist's caseload, this format allows us to focus our attention on individual families, to remain more aware of the impact of multiple services and multiple relationships on families, and to coordinate the home- and center-based portions of our program more effectively. In these weekly hours, the clinical psychologist encourages staff members to explore different ways of thinking about parents' and children's experiences and to reflect on their assessments and interventions. She may meet alone with the infant specialist for part or all of the weekly hour if this seems appropriate and may also schedule extra individual sessions for new staff members.

- **We reserved an hour of our weekly meeting of the entire direct service staff for free group discussion of problems,ideas, program changes, and interventions.** Thus we institutionalized the infant specialists' informal early morning meetings.

Stage IV: Increased infant mental health staffing, including a parent/professional

A mental health perspective had become an integral part of our program's direct services to families, consultation to early intervention staff, and supervisory process. In 1989, we gained a richer parent perspective as well. This came from a new staff member who is a professionally trained infant mental health specialist with personal experience as the parent of a child with developmental disabilities who was served in an early intervention program.

Many families in our program have found the opportunity to share feelings and experiences through support groups and individual parent-to-parent contact uniquely valuable. The addition to our staff of a peer parent who is also professionally trained in infant mental health intervention has offered a new dimension of support to these parents, who often feel cut off from families of typically developing babies. Group and individual counseling may be particularly effective for some families when these services are provided by a parent who has shared some of their experiences in caring for a baby with disabilities.

The current supervision experience

Reflecting on supervision in the Parent Infant Program in its current stage of development, we realize that each infant specialist in our program uses her hour differently. Most of the time, the home visitor and center program coordinator spend part of each hour "checking in" and coordinating home-based and center based approaches. But there is no set format for a supervisory hour, and each infant specialist uses the time according to her own style, interests, and concerns about particular families.

The supervisory hour is a time when the four people in the group (infant specialist, clinical psychologist, center program coordinator, and social worker) can raise questions together about relationship concerns, family dynamics, intervention strategies, or the developmental potential of a child. It is a time when we can consider whether our program is working for a particular family and whether alternative resources are available in the community. We do not expect that an infant specialist will review all her cases or treatment plans each week.

Some vignettes from supervisory hours offer illustrations of issues raised and the way we handle them:

- Supervision helped a new staff member who was unfailingly optimistic about the developmental outcome for even the most severely disabled baby to deal with her feelings when a family found it hard to match her cheery enthusiasm. We were able to discuss the kind of "fix-it" fantasies and expectations frequently generated in working directly with children with disabilities (this staff

member had been a children's speech therapist for many years) and to look at the impact of her own hopeful attitude on this particular family. We thought hard together about what the intervention should be, how the work with the child might feel to the parent, and how the infant specialist could begin to support the parents in their own current experience with the baby, without feeling a failure herself.

- Supervision helped an infant specialist think about how to present to a single parent assessment results that suggested moderate to severe retardation in her infant. We were able to explore the staff member's own ideas about the likely impact of such news on this mother, and her concerns about being one of the professionals discussing this information. Together we identified a style of communication that we thought would be comfortable for the infant specialist and meaningful to the mother.
- Supervision helped a staff member think about a parent's ongoing drug use and the impact it was having on her intervention with the child and family. We were able to discuss the infant specialist's frustration over the failure of previous attempts to discuss this issue with the mother and to devise new strategies for bringing up her concerns. We also talked about options inside and outside the program for additional treatment and the infant specialist's growing concerns about the child's development.
- Supervision helped a staff member explore the complex relationships involved in a child protective services case. An infant who had been in long-term placement with a supportive foster mother, who was an active participant in our program, was suddenly returned to her biological father, who was clearly ambivalent about our services and unclear about our program's connection to his reunification plan. In this situation, we were able regularly to discuss the complexities of establishing a good working alliance with the father so that, among other things, he could help his child cope with the loss of the foster mother, her primary attachment figure. We spent considerable time discussing the feelings that the child's removal from a long-term and loving home aroused in all the staff members who knew this infant.

In general, weekly supervisory meetings with the early intervention staff provide guidance, consultation, and joint problem-solving concerning the relationships between infant specialists and the families with whom they work. Our model of supervision affirms the early intervention staff's expertise in developmental intervention and helps them to address mental health needs of infants and families—and their own feelings in relation to families. Infant specialists do not see themselves as psychotherapists (when appropriate, families can be referred to one of the program's mental health staff for consultation or therapy), but they are comfortable and effective in a role that includes an infant mental health perspective.

Benefits of and constraints on supervision

Our current model of supervision has been in place for two and one-half years. Establishing and using clinical supervision in our early intervention program has required an enduring commitment to the process, a commitment made easier by our dedication to the goal of integrating developmental and mental health services for the population of babies with developmental disabilities and at-risk factors that we serve.

The benefits of this commitment have been considerable.

By recognizing themes that recur in individual supervision hours, we have been able to identify areas where the whole staff can benefit from training and discussion. For example, staff have learned to accept and recognize grief and the different ways parents in our program may express grief as nonpathological (Moses, 1983). Similarly, recognition of differences in the training paradigms of our multidisciplinary staff has enabled us to discuss fruitfully such issues as confidentiality, didactic vs. non didactic intervention, the elements that constitute emotional support to families, and the difference between direct "hands-on" work with infants and working through the parents. Staff as a whole can discuss these conceptual and theoretical issues. In supervision, we can explore the application of concepts and theories to work with individual families.

Supervision has helped us address the feelings staff experience as they work with infants who are disabled, medically fragile, and/or drug-exposed, and with large numbers of multiple problem families. Infants who are not progressing or who are hospitalized repeatedly are now common in our program; it is essential for staff to have a place to explore feelings and potential interventions. Supervision helps staff to become more able to look at their personal effeciveness and styles with families and clearer about the limits to our help and responsibility. We can recognize how important our personal involvement is to families. We can acknowledge how hard our work is. As a result, we see less general anxiety about cases, and a somewhat diminished feeling of burnout.

When staff know that they can receive guidance, feedback, and support each week in supervision, they are more likely to pursue new intervention styles with families. For example, staff members who had been most comfortable working directly with the baby have developed more interest and confidence in working with relationship problems or issues of parental self-esteem. As individual staff members become more flexible, our entire program grows closer to the integrated approach we seek.

Finally, our supervisory model allows early intervention staff and the clinical director to make difficult administrative decisions together. Staff feel a dual loyalty—to the individual families with whom they work and to the program as a whole. When there is a conflict between family needs and what the program, given ever-present

fiscal constraints, can provide, discussion in the supervisory hour about how to proceed can alleviate pressure from the staff. The clinical director takes final responsiblity for administrative decisions.

Although supervision has helped staff and the program as a whole, maintaining our model has not been free of problems. Since four staff members are involved in each hourly supervisory meeting and many staff members work part-time, committing this much time to supervision is not easy, and scheduling itself is extremely difficult. Since we are not a training program, we must continually search for funds to cover the costs of supervision. Finally, the creation of the position of Director of Clinical Services has made a hierarchical structure explicit in a program that had seen itself originally as a "supportive family." The Director of Clinical Services is responsible for both clinical supervision and the yearly staff performance evaluations required by the hospital; she and staff continue to discuss ways of achieving a comfortable, fair evaluation process.

Guidelines for implementing clinical supervision in an early intervention context

Since we began the Parent-Infant Program in 1977, we have experienced a variety of supervisory models, beginning with peer support and most recently featuring individual and small group consultation with a Director of Clinical Services, trained as a clinical psychologist. Supervision has worked as a catalyst to providing more flexible intervention to infants and families,intervention that integrates mental health and developmental perspectives. Although we continue to refine our intervention program and expand our thinking about supervision, we believe that the following guidelines will continue to serve us well:

- **A multidisciplinary program must respect disciplinary differences while integrating perspectives and practice.** In our program, staff members function as general infant development specialists when they work as primary intervenors with families. However, staff members also use their more specific training and expertise in joint consultations or joint home visits with colleagues. In this way we try to learn from each other, expand our understanding of individual children, and recognize the particular contribution of each of our staff members to the program at large.

- **Our current supervisory model recognizes the individuality of staff members and tries to accommodate their individual interests, strengths, and limits.** We encourage staff to work in ways that promote their own sense of success and expand their repertoire of skills and perspectives. Our supervisory model gives staff members time to know each other as individuals and permits regular discussions with infant specialists about the kinds of interventions that they feel most comfortable with, the kinds of situations that are more difficult, and the circumstances in which it would help to involve another staff member for additional intervention with a family. We accept an infant specialist's decision about whether she wants to work with a certain kind of child and family. Demonstrating respect for the individual differences of our staff members helps them to maintain a similar respect for the individual differences of infants and their parents.

- **It has helped to have the supervisory role grow with the program.** Our supervisory model was created, and has changed, in response to the needs of a staff that has grown and changed, in response to the needs of a population of families that is changing continually. We have been fortunate to have had a committed, stable staff since the inception of our program. Our deepening understanding of these individuals, as well as of program needs and goals, has helped us to create a model that is right for us.

Replicating the integration of infant mental health and developmental perspectives

The successful evolution of an integrated model in our program for infants with developmental disabilities has encouraged its application in other early intervention programs within the Child Development Center. Infant mental health specialists have joined the staff of the hospital's Neonatal Follow-up Program for NICU graduates, the NICU Developmental Intervention Program, and an intervention program for drug-exposed, medically high-risk infants. The model of integrated mental health and developmental interventions, with ongoing clinical supervision, is proving its value in the evolution of each of these intervention contexts.

References

Bowlby, J. (1969). *Attachment.* New York: Basic Books, Inc.

Bromwich, R. (1981). *Working with Parents and Infants: An Interactional Approach.* Baltimore: University Park Press.

Greenspan, S. (1981). *Psychopathology and Adaptation in Infancy and Early Childhood.* Clinical Infant Reports Series of the National Center for Clinical Infant Programs, 1. New York: International Universities Press.

Moses, K.L. (1983). The impact of initial diagnosis: Mobilizing family resources. In Mulick, J.A. & Pueschel, S. (Eds.). *Parent-Professional Partnership in Developmental Disability.* Cambridge: Academic Guild Publishers.

Provence, S. (1983). *Infants and Parents: Clinical Case Reports.* Clinical Infant Reports Series of the National Center for Clinical Infant Programs, 2. New York: International Universities Press.

Management in the South Carolina Resource Mothers' Program: The Importance of Supervision

by

Madie A. Robinson
Program Director for Outreach
Department of Health and Environmental Control
Columbia, South Carolina

In South Carolina's Resource Mothers program, women selected for their personal warmth, successful parenting experience, knowledge of community resources, demonstrated ability to accept responsibility, and evidence of natural leadership work with adolescent mothers from their own community during pregnancy and the infant's first year of life. Resource Mothers are expected to assume the roles of Teacher, Role Model, Reinforcer, Facilitator, and Friend. They fulfill these roles by finding potential participants, negotiating a participation agreement with each adolescent, making closely structured home visits, and establishing relationships with the participant, family, school, and community agencies—all with the goal of reducing infant mortality and supporting the development of maternal and infant health competence.

Within the carefully designed relationship between Resource Mother and pregnant adolescent, warmth and closeness flourish. Resource Mothers often accompany girls to the hospital when they go into labor, even in the middle of the night, and stay with them throughout delivery. Young women typically describe their Resource Mothers as being "always someone to care."

We have found that continuing supervision of Resource Mothers by a masters' level social worker is essential to maintain program standards, provide guidance, and enable Resource Mothers to maximize their "natural helping skills." But as the Resource Mothers Program has moved from demonstration grant status (supported originally by a grant to the Medical University of South Carolina by the Robert Wood Johnson Foundation, to implement the Rural Infant Care Project) to become an established component of South Carolina's Division of Maternal Health, it has not been easy to protect an adequate level of supervision. This article will discuss the blend of selection, training and supervision that we have found necessary to help dedicated Resource Mothers fulfill their complex roles.

Selection and training of Resource Mothers

The goal of the Resource Mothers Program is to support the development of maternal and infant health competence, through the use of paraprofessionals. To be eligible for employment as a Resource Mother, a woman must demonstrate personal warmth, successful parenting experience, knowledge of community resources, ability to accept responsibility, and evidence of natural leadership. She must also live in the community where she will work, be willing to be contacted at odd hours, have a car available during work hours, and be a high school graduate.

The origins of South Carolina's Resource Mothers Program

In 1981, South Carolina had the highest infant mortality rate in the nation. Six counties in the Pee Dee Region had an infant mortality rate one and one-half times that of the State rate, and 70 percent higher than the national infant mortality rate from 1976-1981. These circumstances were the basis for a four-year demonstration grant awarded in 1980 to the Medical University of South Carolina by the Robert Wood Johnson Foundation, to implement the Rural Infant Care Project. The goal was to lower the Pee Dee perinatal mortality rate to the State rate. The Rural Infant Care Project was jointly managed and implemented by the Medical University, McLeod Regional Medical Center, Pee Dee Area Health Education Center, and the Department of Health and Environmental Control—Pee Dee I Health District.

A component of the Rural Infant Care Project was the Resource Mothers Program. The Resource Mothers Program was piloted in Dillon, Florence, and Marion counties, all of which were poor, rural, and lacking in accessible health care and educational resources. These areas also constituted "high risk pockets" where health problems had been resistant to traditional interventions.

When Resource Mothers began as a pilot project in 1980, we recruited throughout the three-county target area and invested three months in the selection process. We realized that special efforts to get the best qualified people for the positions were important, because the paraprofessionals' success would be based on their ability to relate effectively to a wide range of individuals, on written and spoken language competence, and on other subtle interpersonal skills.

More than 100 people applied for the six Resource Mothers positions available in the pilot project. Applicants provided basic information in writing about their feelings about children, their work, and community experiences. The social worker and pediatric nurse practitioner interviewed applicants initially; promising candidates were then interviewed by the developmental psychologist and certified nurse midwife. Using rating sheets and group discussion, the team as a whole selected the six Resource Mothers.

An intensive six-week training program for the first group of Resource Mothers was designed to teach, reinforce, and enable them to be positive role models as they worked with pregnant adolescents. The curriculum included material on pregnancy, labor and delivery, family planning, nutrition, communication skills, infant stimulation, home visiting techniques,

well-child development, community resources, referral skills, and work with extended family. Training emphasized inherent strengths, within both the adolescent and her environment, that could be used to enhance decision-making and the development of life skills.

Currently, training is done on the state level in two two-day sessions each year, to develop skills and allow time for the Resource Mothers, now numbering 16 women in 12 counties, to share expertise. Other training opportunities are available through the Division of Maternal Health and inservice programs of other agencies. When a new Resource Mother is hired, the District Coordinator is responsible for her general orientation and instruction in specific content areas. The statewide training sessions offer an opportunity for a new Resource Mother to form relationships with her colleagues from other counties.

Supervision of Resource Mothers

As the demonstration phase of the Resource Mothers Program evolved, a masters level social worker, using a "social support" model of supervision, assumed responsibility for weekly supervision of each Resource Mother. The supervisor helped the Resource Mother to understand the principles underlying her work with adolescent mothers, their families, and the health care system, rather than telling the Resource Mother what to do in any given situation. In addition, because the use of paraprofessionals was new in the region's health care system, the supervisor took on the role of liaison between Resource Mothers and professional service providers. The supervisor identified and clarified the Resource Mothers' role within the health care system. She assured professionals and administrators that the goal of the project was to enhance, not to undermine their work, and that Resource Mothers would help pregnant adolescents become better users of established health care services. To make this possible, the supervisor assisted Resource Mothers in identifying barriers to care and in working with and through systems, as well as in supporting and reinforcing adolescents in appropriate behavior.

Now that the Resource Mothers Program is part of the Department of Health and Environmental Control, a State Program Director is responsible for overall supervision and coordination of the program. Four District Coordinator/Supervisors, under the supervision of District Social Work Directors, are responsible for the hiring, training, and day-to-day supervision of Resource Mothers. District Coordinator/Supervisors are also responsible for working with nurses, social workers, nutritionists, health educators, physicians, and other health professionals to get referrals for Resource Mothers, and to negotiate potential systems barriers. Finally, the District Coordinator/Supervisor may intervene directly in cases that need intensive follow up; she has, in effect, a caseload of her own.

Supervision of Resource Mothers includes monthly group conferences to review patient caseloads, solve problems, and provide continuing education in specific subject areas. The District Coordinator/Supervisor makes one supervisory home visit monthly with each Resource Mother. In individual conferences, held at least monthly, the Coordinator/Supervisor reviews the Resource Mother's entire caseload and helps her to work with selected cases, acquire insights into human behavior and relationships, use resources, and modify systems barriers to the services adolescent mothers need. Conferences focus particularly on identifying patient and family strengths, helping teens understand the need for good maternal and infant health, and resolving specific problems.

The following vignette illustrates the issues that may arise in supervision.

Kecia delivered her first child, a 5 lb., 8 oz. boy, when she was 16 years old. Kecia lives with her widowed father and three younger siblings; she is expected to handle all household duties as well as care for Johnny. The baby's father is not involved, and this is a problem for Kecia. By almost three months after his birth, Johnny had gained less than a pound and did not seem alert to his surroundings. The nutrition staff at the clinic gave Kecia advice on feeding, but the baby did not gain weight. Mrs. A., the Resource Mother working with Kecia, explained to her the consequences for Johnny of continued failure to thrive. Mrs. A. did not understand why Kecia was not following the nutritionist's directions, even though Mrs. A. repeated them to Kecia during each home visit.

Here the Supervisor needed to address relationships on several levels. Resource Mothers generally feel so close to program participants that they refer to them as "my girl" and "my baby" when discussing cases with each other. But Mrs. A. and Kecia had not begun to work together until late in Kecia's pregnancy and had not developed, before delivery, a high level of trust. Another issue of trust involved Mrs. A. and the clinic nutritionist. When the Resource Mothers Program became part of the health department, we learned that some professionals were uncomfortable with the idea of paraprofessionals functioning so independently. Paraprofessional Nursing Assistants or Community Health Aides were visible in the clinics, but the Resource Mothers' activities, taking place in homes and in the community, are less visible and may be undervalued.

The Supervisor worked with Mrs. A. to help her consider Kecia's experience as a new mother who had recently lost her own mother, could not count on her baby's father (whom she had previously trusted), and had no real support system for herself. The Supervisor emphasized the need to develop a relationship with Kecia before any other progress was possible. At the same time, the Supervisor emphasized Mrs. A.'s value as a member of the health team concerned about Johnny and Kecia—both to Mrs. A. herself, and to professional team members.

Unfortunately, this model of supervision has been compromised since the Resource Mothers Program became part of the state public health system. District

Coordinator/Supervisors have been assigned to provide direct service as social workers in public health clinics. The demands of clinic work reduce supervisors' ability to review regularly and consistently the 60-65 cases carried by each Resource Mother. The time that supervisors have available, especially for individual conferences with Resource Mothers, has decreased, as has their day-to-day accessibility to the Resource Mothers.

Faced with diminished guidance and support, some Resource Mothers have coped by persuading themselves, consciously or unconsciously, that they can handle difficult situations without supervision. The danger, where these energetic, dedicated women are concerned, is not that they will slacken their efforts without supervision, but rather that they will try to do too much.

Resource Mother B. was working with Pam, a 16-year-old who was seven months pregnant, anemic, and having multiple family problems, especially with her mother. One night, after an argument and some physical confrontation with another sibling in the home, Pam's mother put her out, with no place to go. Pam called her Resource Mother, who took Pam to her own home for the rest of the night. Although Ms. B. had received training about what to do in situations of abuse and neglect, she did not contact her supervisor. The supervisor first found out what had happened the next day, when Pam's mother called the program, trying to locate her daughter. When the supervisor was finally able, after several tries, to reach the Resource Mother, she learned that Ms. B. and Pam had already gone to the Housing Authority to apply for housing for Pam.

Ms. B. had been doing her best to fill the role of "friend" to Pam. She sought to help the girl but failed to understand the danger in which she put herself during the middle-of-the-night "rescue" or to think the situation through clearly. She did not see the need, at the time, for consultation with her supervisor. It is only regular, individual conferences that give a skilled supervisor time to ask leading questions and carefully probe suspicious-sounding situations.

Andrea was a 17-year-old experiencing her first pregnancy. She had strong feelings for Joe, 19, the father of the baby, but was only seeing him off and on. He was seeing other girls. Andrea was so upset that she swallowed 11 prescription pain relief tablets. After she was taken to the emergency room, she called Mrs. C., her Resource Mother, to tell her what happened. There was no harm to the fetus or to Andrea, and she was sent home after some hours of observation. The Resource Mother decided not to inform her Supervisor about the incident immediately, but to wait until her scheduled supervisory conference, later in the week.

Mrs. C. first told her Supervisor about Andrea's gesture in a casual conversation several days after the incident. When the Supervisor asked Mrs. C. why she had not told her about the incident immediately, Mrs. C. replied, "I was going to tell you during our conference. I didn't want to call and bother you over at the clinic—I know you're so busy. Anyway, Andrea said she didn't mean to kill herself, just create a scare." Mrs. C. continued, "I talked to her, and I don't think she needs to go to Mental Health, but maybe get some family counseling."

One has to be very careful in helping paraprofessionals to understand their limitations. It is true in many instances that Resource Mothers have a closer working relationship than any professional with many program participants, and that they indeed know a great deal more about participants' everyday situations because they are constantly in and out of their homes. But while Resource Mothers receive some training in counseling patients in various situations, they do not understand all of the dynamics involved in crisis intervention. The Coordinator/Supervisor's responsibility is to help the Resource Mother understand how she fits into the entire service team. The Supervisor can and should acknowledge that the Resource Mother may be the most positive force in an adolescent's life, but the Supervisor must also, supportively but effectively, help the Resource Mother understand the limitations of her role.

Being "professional"—for professionals and paraprofessionals alike—involves calling for consultation and assistance in order to provide participants with the best quality services possible. In this instance, the Supervisor discussed with Mrs. C. what might have happened if Andrea had succeeded in committing suicide, reviewing not only the tragic consequences for Andrea and her family, but also the potential impact on the professional careers of the Resource Mother and Coordinator/Supervisor and on the entire Resource Mother Program.

The two incidents above, and other less dramatic examples, have taught us the dangers of failing to maintain adequate professional supervision in a service program. We are moving toward restoring the weekly individual supervisory conferences that were in place during the demonstration grant phase of our program and are reducing the clinic responsibilities of District Coordinator/Supervisors so that they can be more easily accessible to Resource Mothers.

Some lessons from experience

South Carolina's Resource Mothers are extremely proud, dedicated, and serious about the work that they do. If they and other paraprofessionals are to be successful within a health care bureaucracy, they need support, flexibility, and supervision. A careful selection process, appropriate training, clearly defined tasks, and professional social work supervision are all factors that we believe have contributed to the successes of South Carolina's Resource Mothers Program. As others look to the Resource Mothers model as an effective, efficient response to a major national health problem, we urge that ongoing training and supervision be recognized as essential to the establishment and maintenance of high program standards and to the achievement of our ultimate goal—healthy and competent mothers and infants.

Toward Tenacity of Commitment: Understanding and Modifying Institutional Practices and Individual Responses that Impede Work with Multi-problem Families

by

Barbara Fields, M.A., C.S.W.
New Rochelle, New York

Editors' note:

In this essay, published originally in the June, 1987 Zero to Three, *Barbara Fields urges infant/family practitioners to look at two sets of feelings they experience in their work—those associated with the administration and supervisory structure of their workplace, and those elicited by children and parents themselves. This twin focus has informed much of NCCIP's own organizational thinking about supervision and mentorship in infant/family practice since 1987, and the reprint requests we receive suggest that the essay continues to be influential throughout our field. We reprint it here so that is can be read conveniently in conjunction with the other articles on supervision, mentorship, and professional development that make up this issue of* Zero to Three.

Intensive work with multi-problem families can be immensely satisfying, but it is also emotionally and physically depleting, and at times unrewarding. While the despair and frustration of members of such families have been amply reported, the feelings of clinicians who work with these high-risk infants and their parents have received scant attention. I believe that it is important to look at two sets of feelings that practitioners who work with this population may experience—first, those feelings associated with the administration and supervisory structure of the settings in which the work is done, and second, those feelings that are elicited by children and parents themselves. Many such emotional responses can cause even an experienced clinician a great deal of discomfort, and, if denied, can seriously interfere with treatment. If, on the other hand, we can understand our own feelings and those of our colleagues and supervisees, we may be better able to support each other in the difficult work we do and to serve deeply troubled families with greater compassion and skill.

Because multi-problem families present such an array of difficulties, workers from a variety of disciplines may find themselves in one way or another involved with them. Thus, clinicians who work primarily with children whose biogenetic endowment is compromised are seeing an increasing number of organically impaired infants born to multi-problem families. Not only must additional services be provided for these infants and parents, but professional in such fields as special education, occupational therapy, physical therapy, nursing, and speech, language and hearing also need to expand their conceptual and clinical framework in order to address the problems these families face. At the same time, many of us in the mental health professions are realizing the need to deepen our conceptual and clinical understanding of multi-problem families, particularly since we now realize that traditional psychological and psychiatric interventions have failed at the most basic level, that of developing and sustaining meaningful contact with members of these families.

Unfortunately, the service providers who are faced with meeting the range of interrelated developmental and parental needs presented by multi-problem families seldom have training beyond that required by their specific discipline, and have little access to new advances in developmental and clinical formulations. They have, in particular, little formal pre-service training or on-the-job guidance in recognizing, understanding, and ultimately using the powerful feelings that inevitably accompany work with this population.

Confronting an array of difficulties

As service providers working with children from birth to three, we are charged with the challenging task of developing and implementing programs in a range of primary care settings for infants and their families.

These infants and parents fall roughly into two categories, with a great deal of crossover between groups. In one group are babies whose biogenetic endowment renders them developmentally vulnerable. Parents of these children are faced with the critical task of promoting optimal growth in their handicapped infant while concurrently attempting to work through their own complex responses to feelings of defect and deficit in themselves and their child.

In the second group are infants who are considered developmentally at risk due to serious limitations in their caregiving environment. These infants usually are referred for preventive intervention or for alleviation of the symptoms of developmental stress, distortion and delay they already exhibit as babies and toddlers. (Fraiberg, 1980, Provence and Naylor, 1983, Greenspan, et al., 1987). Additionally, these children may be organically impaired. The children in this second group belong to what are commonly described as multi-problem families. These families, designated also as hard-to-reach or multi-risk, are characterized by an array of individual, parental and environmental problems which call for new and creative approaches to meet their multiple, interrelated psychological and concrete needs.

As I have suggested, feelings associated with our work are of two types, related to the administrative and supervisory structure of the setting in which we work, and to the children and families we serve in one form or another. These latter responses may have to do with the feelings, impulses and ideas that are elicited in the clinician by the case material or by behavior reflecting the child's or parent's inner life. I will describe some of my own responses to a particular parent that contributed to an unsuccessful outcome because I did not understand them well enough at the time. Before I do that, however, I want to discuss feelings related

to administrative and supervisory practice which also elicit responses that can profoundly affect our work.

Institutional practices

It is my contention that unquestioned institutional practices contribute all too frequently to feelings of futility and anger on the part of staff. Interestingly, clinicians' responses to the institutions in which they work are similar to feelings of hopelessness, helplessness, anger and despair expressed, usually behaviorally, by the families they treat. These responses are also similar to feelings of anger and futility we may have toward and about a particular child and parent at various points in the treatment process. (J. Fields, Yorburg and Turkel, 1970, Rigamer and J. Fields, 1971).

It is generally agreed that certain elements in any program have enormous influence on the overall attitudes and morale of staff. Provence and Naylor describe staff support as taking several forms including intellectual stimulation, an atmosphere of intellectual inquiry and curiosity, the ability to respond promptly to staff members' distress about problems with a parent or child, and provision of channels to address the inevitable strain that arises among people working together.

In most settings, however, inordinate and pressing demands upon administrators force them to subordinate their efforts to provide the climate of intellectual inquiry, training and empathy with staff concerns that Provence and Naylor suggest is vital to effective intervention. Beyond this, recent advances in the understanding of developmental processes have not yet been well integrated into the training components of many primary care settings. But with multi-problem families, the ability to conceptualize issues and treatment approaches is particularly essential for staff, adding a dimension that increases theoretical and clinical mastery. Without this dimension, staff feels at sea, puzzled by issues they cannot understand or grasp, and dependent upon traditional interventions that at best address a few aspects of a multi-faceted problem.

As early as 1970, J. Fields et al. drew attention to another administrative dilemma—that the time needed for staff to understand and assess each family in depth, and to provide meaningful intervention over time, is incompatible with the inordinately high caseloads and extensive paperwork many agencies require. Seventeen years later, there have been no apparent changes in agency practice, and the question Fields and his colleagues posed then is equally relevant today. Since most of the families we see require more, not less time to address their multiple needs, why is it almost a matter of unquestioned policy to assign more cases to staff members than they can possible manage?

As Fields, et al. suggest, one result of such practice is a staff that is often harried, overwhelmed, dissatisfied and unable to utilize their individual talents and knowledge. Administrators are forced to focus their energies on meeting the demands of funding sources and spend whatever time is left over meeting a variety of crises. Staff development and support necessarily falls lower and lower on their list of priorities. Supervisors are responsible for more cases than they can handle. In my experience, in all but a few demonstration settings, supervisory conferences of necessity consisted of highlighting the most critical aspects of eight or nine cases rather than an in-depth scrutiny of their theoretical and clinical issues. Case conferences as well tended to focus on management rather than on deepening conceptual and clinical understanding.

Additionally, the bureaucracy beyond the immediate work setting may negatively affect staff morale. For example, departments in many hospitals are run like small fiefdoms with little communication between disciplines. A physical therapy department without a social worker can refer a parent for mental health intervention—but then what? Unless the physical therapist and the mental health worker communicate informally or convene a special case conference, they often operate independently of each other, limiting effective intervention. Further, this fragmented treatment approach runs counter to new advances in developmental and clinical formulations that see development as involving multiple, interrelated pathways and needs that are most effectively addressed by a well integrated approach on the part of the individual practitioner and by the interdisciplinary team.

Caseloads that are too large, inadequate time for assessing and understanding each family in depth, insufficient intellectual stimulation, or training that does not encompass more recent formulations, and supervision that tends to be superficial, crisis oriented and limited in conceptual scope, along with a fragmented treatment approach, lead to the demoralization of both senior and junior staff. Feelings evoked are those of personal and professional inadequacy, incompetence, dissatisfaction, anger, helplessness, and despair.

Painful as these feelings are in themselves, the lack of their validation by administrators and supervisors can lower staff morale further. And it is often the case that overwhelmed administrators and supervisors, responsible for the overall program, feel criticized when negative feelings are voiced and therefore discourage their expression. Conflicts which arise among members of various disciplines as they attempt to work together can be another source of stress. These conflicts derive in part from honest disagreements about the best course to pursue in a given case, but just as often involve territorial or competitive feelings which are difficult to sort out in the best of circumstances and almost impossible to resolve in the climate described.

Psychological factors influencing effectiveness

The discussion so far has focused on those elements in administrative structure and practice which can contribute positively or negatively to staff feelings of competence and selfworth. I want to turn now to psychological factors that have equal impact in affecting the overall effectiveness of staff.

It is my impression, shared by others (Rigamer and Fields; Fraiberg; Provence and Naylor), that these more elusive factors stem from countertransference issues that staff encounters in work with high-risk families. The term "countertransference" is meant by the authors cited, and by this author, to include all emotional responses on the part of the clinician toward or about the individual he or she treats. Further, it is generally agreed that countertransference, in this broad interpretation, is a factor in all levels of intervention in work with young children and their families, from home visits geared to the transmission of parenting skills to psychotherapy. Countertransference critically affects outcome. As Rigamer and Fields specifically note, the clinician's emotional responses require continual self-monitoring and attempts at self awareness. Indeed the clinician can make good use of these responses in work with multi-problem families but only to the extent that he or she is aware of them.

For example, some years ago I was assigned as the social worker for an 18-year-old woman whose baby was enrolled in the program in which I worked. Nancy was an angry and defiant young woman, prone to aggressive and sexual acting out. She tended to view people as all good or all bad, and had marked mood swings, reflecting a relatively primitive inner life and level of functioning. Many early developmental tasks had been poorly negotiated or not achieved. These traits also were reflected in Nancy's behavior toward her infant son. While she was not especially physically abusive, Nancy was extremely neglectful and both rejecting and overstimulating, depending on her mood. She found it difficult to allow David even the autonomy to explore a toy in his own way—he was to explore it "the right way," ie., her way or not at all. Further, although Nancy presented herself in crisis after crisis and seemed beset by inner and external stress, she frustrated all attempts to help her. She was unable, for instance, to keep appointments that would confer eligibility for public assistance, necessitating beginning the entire process again and again.

Soon after we met, Nancy began extolling my virtues to everyone in our center, to the extent that some of the other mothers began to express envious and competitive feelings. Needless to say, the tables soon turned and I became as despised as I had been admired, and Nancy did not hesitate to express these feelings about me either! What I had done, if anything, to incur such intense rage is still unclear. The important fact is that after my initial attempts to sort out Nancy's seemingly sudden change in feelings were met by continued hostility, I began to distance myself emotionally and even physically from her, avoiding going to the infant room, which I supervised, when I knew she would be there. First of all, I am embarrassed to admit, my pride was hurt. Although I had thought I had been well aware of the quixotic nature of Nancy's positive feelings for me, I realized a part of me had really warmed to her many compliments. More significantly, issues in my own history and inner life made me unrealistically afraid of Nancy. Her unpredictability, loose boundaries, highly charged emotions, and primitive level of functioning stirred up a complexity of uncomfortable feelings. My defense against these feelings was to distance myself and to view Nancy's situation and any possibility for change as hopeless. Not only did I view Nancy through this darkened lens, the entire staff began to complain about the futility of treating her and her child (an idea used by all of us to further justify minimum engagement). If I had been more aware, I might, at this point, have been an advocate for Nancy with day care staff, helping them to understand the roots of her behavior and planning with them some alternative, possibly more effective interventions with this young woman and her little boy.

It is important to mention that initially I was only half aware of my discomfort and only somewhat more aware of my wish to avoid Nancy. In addition, because of the urgency that surrounds our work, I had seven or eight other mothers who also needed my attention. I found myself thinking less and less about Nancy and incresingly about other, less nettlesome mothers and babies. More honestly stated, this shift in focus became a defense against scrutinizing my responses to Nancy. It took time to sort out the feelings described, and longer to understand how they might have interfered with treatment. The major point is that while it is uncertain whether or not Nancy could have formed a therapeutic relationship, my feelings may have contributed as much to the therapeutic stalemate as did Nancy's own characteristics.

Awareness of feelings: A catalyst for growth

I have described my experience with Nancy for two reasons. First, and most important, although I was unable to establish the kind of relationship with her that might have led to even incremental change, I learned about aspects of myself that became a catalyst for personal and professional growth. I have since worked with a number of mothers whose problems were similar to Nancy's. My work with them has been more successful not simply because I have become more clinically sophisticated or have additional years of experience, but because I am more aware of the inner forces which shape my particular responses toward these young women. Without careful monitoring of our own responses, including an awareness of the kinds of defenses we are likely to use in warding off uncomfortable or painful feelings, it is difficult, if not impossible, to distinguish between families with whom a therapeutic relationship truly cannot be forged despite all our best efforts, and those whose treatment is impeded by countertransference issues that are not well understood or even within our conscious awareness.

It is equally important, however, to consider institutional practices as they contribute to, and in some instances actually support typical countertransference problems encountered in work with hard-to-reach families. As Rigamer and Fields point out, in settings

where the pressure for service and the urgency of need is great, it becomes especially easy to withdraw from individuals who are trying, or whose problems are chronic and seemingly "refractory to treatment." Unable to grasp the real nature of their problems and/or unaware of our own responses, we begin to share the hopelessness of those we seek to treat, become frustrated or angry at what looks like their stubborn resistance to our intervention, and feel there is little we can do. We begin to feel relieved when family members fail to keep their appointments and view their "recalcitrance" as further proof that intervention is futile. This sense of futility is often supported by the supervisor whose sense of annoyance with the therapist is only once removed from the family itself (Rigamer and Fields). Both therapist and supervisor eventually relegate such families to the bottom of their list with the tacit agreement that they are "unworkable." If this state of affairs continues, the family will resist whatever level of intervention is offered or will remove their child from the program. This all-too-frequent scenario contributes to a loss of self-esteem (not being able to adequately do one's job), and a sense of hopelessness, helplessness and anger in practitioner, supervisor, and administrator, who begin to blame each other and the family for the unsuccessful outcome. Since members of multi-problem families struggle with similar feelings, long before intervention is officially deemed a failure a pervasive sense of futility has most likely become an unacknowledged accompaniment to the therapeutic work, precluding the sense of competency and efficacy we want to feel about ourselves as clinicians and to impart to the families we treat.

Is improvement possible in the "real" world?

Most of us do not work in demonstration projects. On the contrary, we try to serve multi-problem families in programs that themselves face multiple problems. Given the fact that meeting institutional, administrative and clinical demands takes up most available working time, how can administrators promote an atmosphere of intellectual inquiry and emotional support among staff? How can administrators prepare themselves and their trainees to be more aware of their responses to agency presures and to participating families? How can administrators help themselves and their trainees to cope with these feelings more successfully?

We do know that a climate of openness is conducive to promoting both intellectual curiosity and the expression of attitudes, feelings, and ideas. Creating such a climate presents a challenge to administrators, but I think it is a challenge that can be met, at least on some levels and to some extent. For example, I urge senior staff to think about how new advances in theoretical and clinical understanding can be conceptualized for staff in ways that apply to the problems they bring to supervisors or case conferences about a specific parent or child.

I also recommend that supervisors become more open in recounting to those they supervise, their own experiences with hard-to-reach families. The critical nature and special pressures inherent in our work often produce feelings of vulnerability in staff about their own knowledge and skills. In addition, as my experience with Nancy suggests, some of our responses to these families can cause a fair amount of discomfort. For both these reasons, it is important for trainees to hear about their supervisor's experience—blunders as well as success—and of the supervisor's struggle to make sense of the problems she or he faced in learning to work productively with these troubled families. In such a climate, less experienced staff might feel freer to ask questions and to express their own feelings, attitudes and ideas without fear of judgment. Just as traditional interventions with multi-problem families need to be modified or expanded in scope, traditional modes of supervision also may need modifying with the aim of facilitating the kind of dialogue between supervisor and supervisee that helps the latter to understand and feel comfortable about a range of responses. The degree to which this can be accomplished depends in large part upon the supervisor's ability to accept disturbing feelings in him or herself and others.

I want to end on a note of encouragement. Probably the most helpful analogy I can make to work with multi-problem families is that of raising children. This analogy rests not on the attributes of the individuals we are trying to help, but on the degree of commitment needed. Just as parents must be able to sustain their relationship with their growing children through difficult emotional times, so clinicians need to pursue their relationship with members of multi-problem families despite moments when a complex of negative or ambivalent feelings threatens the integrity of the therapeutic bond. This commitment is in itself rewarding. The tenacity of this commitment can often bring, in its wake, meaningful environmental and psychological change.

References

Fields, J.H., Yorburg, L., Turkel, M. (1970) The quest towards treating the untreatable. Presented at the Philadelphia Meeting of the American Association of Psychiatric Services for Children.

Fraiberg, S. (1980) *Clinical Studies in Infant Mental Health: The First Year of Life.* New York: Basic Books.

Greenspan, S., Wieder, S., Nover, R., Lieberman, A., Lourie, R., Robinson, M. (1987) *Infants in Multirisk Families: Case Studies in Preventive Intervention.* Madison, Connecticut: International Universities Press.

Provence, S., and Naylor, A. (1983) *Working With Disadvantaged Parents and Their Children.* New Haven and London: Yale University Press.

Rigamer, E. and Fields, J.H. (1971) Hopelessness and the therapist. Presented at the American Academy of Child Psychiatry, Boston.

A Seminar for Supervisors in Infant/Family Programs: Growing versus Paying More for Staying the Same

by

Judith Bertacchi, The Virginia Frank Child Development Center of the Jewish Family and Community Service
Frances M. Stott, Erikson Institute
Chicago, Illinois

"There was that law of life so cruel and so just which demanded that one must grow, or pay more for remaining the same."
—Norman Mailer, *The Deer Park*

Leaders in the "helping professions"—especially women—struggle with experiencing anger and establishing and enforcing rules. Making judgments, setting limits, and dismissing staff members do not come easily, but they are part of a program director's obligation to ensure good service to program participants. Leaders in the helping professions commonly feel isolated, without peers to share their pain and difficulties. Few have had training in the process of intervention with staff or the relationships involved.

Recognizing these problems, Linda Gilkerson, Co-Director of Erikson Institute's Irving B. Harris Infant Studies Program, conceived the idea of a seminar for people in supervisory positions in programs serving infants, toddlers and their families. For the past three years, we have invited eight to ten administrators or program directors from early intervention, child care, family support, and hospital-based programs in the Chicago area to participate in a nine-session supervision seminar. The sessions are held every other week on Friday afternoons; the atmosphere is informal, and members bring refreshments.

The supervision seminar reflects Erikson Institute's conviction that good supervision is one of the keys to developing competence in students and to establishing and maintaining quality in service programs. The supervisory process is intensive and time-consuming. The supervisory relationship is a mechanism for teaching, solving problems, and helping supervisees make both "outer" changes in their skills and "inner" changes in their image and use of the professional self. In most programs serving young children and families, supervisors must also evaluate the job performance of supervisees and make judgments about the promotion, reassignment, or dismissal of staff members. As co-leaders of the seminar for supervisors, we have crafted a model based on psychodynamic theory, supervisory tenets drawn from the professional literature, and principles derived from clinical practice with families and young children. The seminar addresses leaders' isolation by providing a forum for exchange. It uses a process model to help directors broaden their professional identity to include new competencies.

As co-leaders we assist those responsible for supervising the daily practice of others to examine such issues as:

- understanding oneself and using oneself as a vehicle for good practice;
- learning how to establish and maintain a supervisory relationship, particularly in difficult circumstances; and
- learning how to ensure that professional goals of staff match program goals.

We designed the seminar on the assumption that once members have experienced the process, they will be better able to make supervisory and administrative decisions on their own, or know how to get consultation for themselves built into their program budgets. Our experience with the first seminar groups has confirmed this hypothesis.

The seminar does not teach the tenets of supervision directly. Although we provide readings and a bibliography on supervision, these are not required reading and are brought up during the seminar only if one of the group members chooses to do so. The focus of the group is on problem solving. We model leadership by dealing honestly and forthrightly with issues that arise inevitably in the work of supervising staff and, in some cases, administering a program.

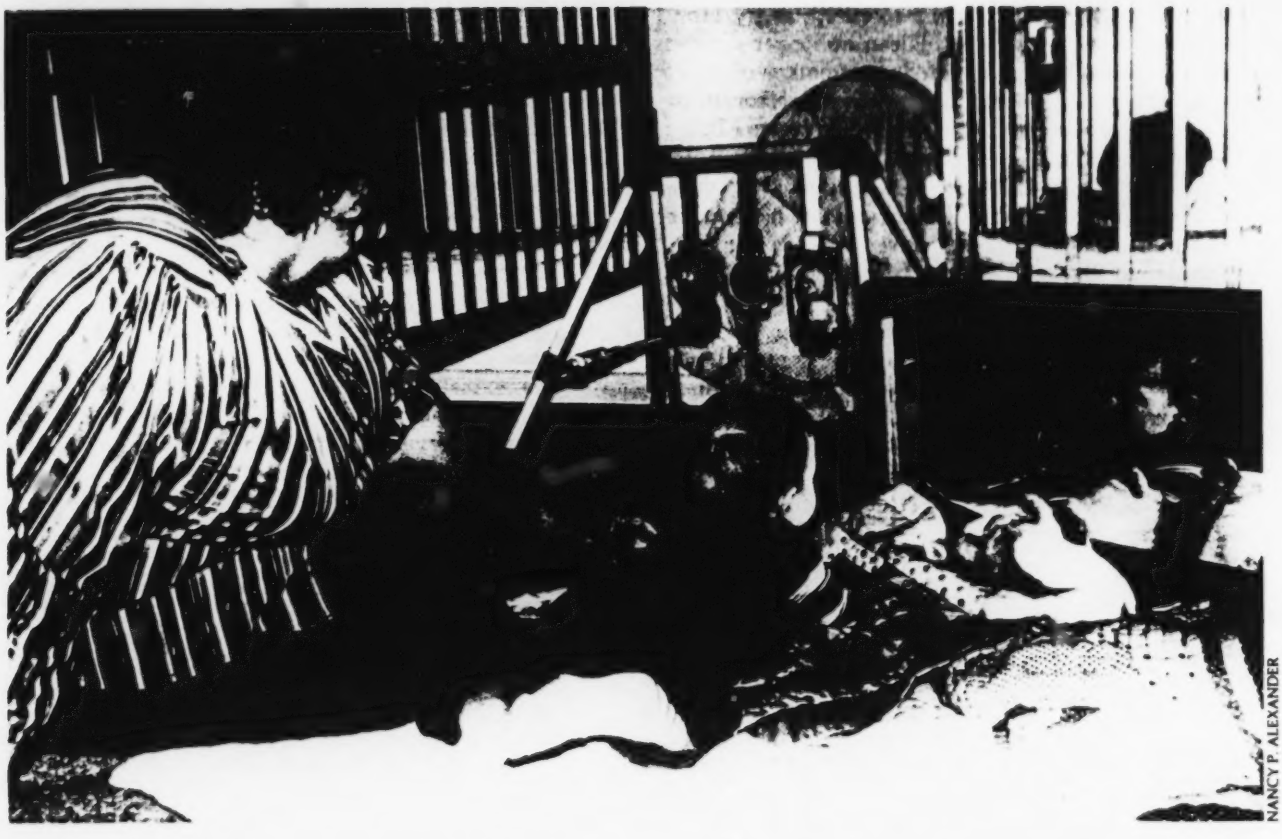
The focus of the seminar for the supervisors is on problem solving. We model leadership by dealing honestly and forthrightly with issues that arise inevitably in the work of supervising staff and administering a program.

Interestingly, the work problems that group members present typically have very little to do with the dynamics of families or children being served, but involve, rather, the struggles that supervisors and supervisees experience within agency or institutional systems. Of course, families are in our discussions—indirectly. The emotions that are connected to the struggles and pain of families with problems or compromised infants permeate our working atmosphere. And families' struggles are reflected in supervisors' struggles with staff. We see a series of parallel processes going on.

The following vignettes (with details changed to protect confidentiality) illustrate the process of the seminar for supervisors. Basic themes are raised in the vignettes—including the mutual sharing and clarification of expectations, the role of the supervisor as change agent, the handling of strong emotions and conflict, and distinctions between supervision and consultation.

Eileen, Annie, and Helen

Eileen, a member of the seminar, supervises a large staff in a successful urban corporate day care center for employees whose children are 6 weeks to 5 years of age. In the first meeting of the seminar, she presented for discussion a problem involving a work violation by one of her staff members. She was pressed for time, she said, because the problem demanded an immediate intervention and possible sanctions.



NANCY P. ALEXANDER

Eileen told us that Annie, an experienced assistant teacher in the infant room, had begun to harass Helen, the newly hired young head teacher. The harassment, according to Helen, involved verbal slurs about Helen's competence, usually made within earshot of other staff members. Annie also made sarcastic comments directly to Helen, especially when Helen was picking up one of the babies that Annie thought should be left alone for awhile. These verbal attacks had begun to escalate to veiled threats to Helen both in and out of the day care setting. Annie also had begun first to avoid, and then to refuse to work with individual babies when Helen differed with a care plan initiated by Annie.

Helen had demanded of Eileen that Annie be disciplined, as she was fast becoming both afraid of Annie and enraged at her. Other experienced day care staff members had also approached Eileen and had given her their ideas of how this now impossible situation should be handled. Several had confided their suspicions that Annie might have an addiction problem (but never on the job!). Everyone knew that Annie had a young child with severe developmental disabilities, for whose care she was responsible when she was not working. Annie's old colleagues had begged Eileen to urge, if not force Annie to use the Employee Assistance Program that was available to her as a staff member.

Eileen said that after she gathered the facts from Helen privately, she called Annie into her office, reviewed the details with her, and suspended her for a few days. Annie left Eileen's office self-possessed and without saying a word. When Helen learned through the center grapevine about the disciplinary action, she asked to see Eileen and demanded a stronger sanction. She felt the suspension was "too little" for "too much."

At this point in Eileen's exposition of the problem in the seminar, one of the leaders interrupted and began to ask questions to gather more details. Eileen told us that Annie saw Helen as having an "attitude" problem and thought Helen saw her as "lowly." Using dynamic terms, we re-framed Annie's feelings for Helen as a powerful negative transference. We took this opportunity to teach the group about the broadest meaning of "transference"—that is, the projection of relationships from the past onto a person in the present, regardless of whether such a correspondence is logical, deserved, sensible, etc. We emphasized that this is an *unconscious* process at work, beyond a person's control.

We went on to explore Helen's position as a victim. Since Helen was clearly the target of unjustified and upsetting behavior, we wondered why Helen had not stood up to Annie directly, as well as (rightfully) reporting this conduct immediately to her supervisor. This work problem now clearly involved two players. Helen's passivity toward Annie may in fact have escalated the conflict. It became clear to us that whatever happened in the future, Helen and Annie should not be together in the present.

Before a solution to the problem could be developed, we needed to help Eileen explore and review her own alliances and allegiances. As Eileen shared more

information with us, she became increasingly angry. From our point of view as outsiders, Eileen no longer seemed to be a neutral problem-solver. In a moment of great honesty, Eileen said that if there were no personnel or legal restraints to be considered, she would feel like firing Annie on the spot. She followed this revelation by increasingly judgmental statements, such as: "We're supposed to be adults here ... jobs are not being done ... children are not being well served ... I do not want Helen to quit; it is damned difficult to get trained people to commit to this work."

Fran intervened here (as we will discuss later, our two-leader model allows one leader to question and probe while the other is available to monitor group process and protect group members) and asked Eileen, "How did you start your career?" Eileen responded, slowly and thoughtfully, "I began as a young head teacher in a day care center." Fran went on, "So you identify with Helen." Again, with great honesty, Eileen said, "I guess I do. I hadn't even thought of that."

Valuing change intellectually is very different from being faced with personal issues that we are not aware of, that others are aware of, and that are impeding our work.

Fran's gentle but direct question had invited Eileen to slow down and spend some time reviewing her own feelings and identifications. The major supervisory issue we were looking at as a group involved a supervisor's need, in many situations, to gather facts thoroughly, but also to listen carefully to the supervisee's unspoken dilemma, conflict, or problem. The supervisor must also review and evaluate his or her own circumstances and feelings before making a decision. In this situation, Eileen's personal and professional identification with one of the staff could have resulted in an incomplete or biased analysis of the problem. By intervening while Eileen described the situation as she saw it, Fran invited Eileen to become introspective as she reviewed her own identifications (transferences) with staff. Eileen was momentarily startled and embarrassed, then reflective.

We reminded the group that valuing change intellectually is very different from being faced with personal issues that we are not aware of, that others *are* aware of, and that are impeding our work. The supervisory struggle among Eileen and her two staff members was now taking place between Fran and Eileen. Fran, as consultant, could see Eileen's problem. Her goal was to assist the supervisee (Eileen), within the context of a supportive relationship, so that internal, and later external, changes could occur. Fran acted to help Eileen change her *perspective* so that she could then use a different *strategy* in her supervisory relationship. Fran took the risk, which is inherent in every supervisory practice, of entering and even creating conflict in the present, and of keeping conflict in the spotlight so that learning and change could proceed.

This review and insight brought Eileen closer to a neutral stance. She then shared even more information about Annie's history. Eileen told us that Annie had had a stressful childhood and a troubled adolescence, marked by many losses, which culminated in the birth of her disabled child. Annie also had many strengths, including a will of iron and commitment to her child, her job, and Eileen, who had gone to bat for Annie at the beginning of her employment.

The seminar group began to resist any further disclosure of Annie's history. One member said quite directly, "Talking about Annie makes me feel nervous." Recognizing mounting discomfort in the group, we took time to explain that understanding a person and something of his or her history could help inform supervisory intervention. We introduced the concept of repetition compulsion: the overwhelming urge or need to repeat in the present the same behavior or cycle of behaviors that one constructed in the past in an effort to cope or adapt—regardless of whether these patterns serve the person well in the present. We suggested that a repetition compulsion being played out by Annie and Helen constituted one of the barriers to solving their problem at work. If Eileen could recognize the re-enactment of the past by Annie and/or Helen in the work setting, she could plan a supervisory intervention that would avoid her replaying or being "scripted into an old part" of either Annie's or Helen's enduring issues. We pointed out the difference between a supervisory relationship and a treatment relationship, in which client and therapist contract to work directly on highly personal issues.

As Eileen shared more information about Annie, we could see links between elements of Annie's history that involved acting out, dishonesty, and loss, and her current behavior with Helen. Over and over again, vignettes from Annie's past ended with Annie's "being cut off" or "cutting off." It was this recurrent theme that provided a key to understanding what was needed and that directed our work with Eileen as she moved toward a solution.

We then connected the reality of Annie's job performance to a review of work standards and ethics. We used the group's discussion of work standards in general to move toward a discussion of role boundaries and specific performance standards. The group agreed that Annie was currently unable to act within these parameters, and this time the discussion of her job behavior was based on better knowledge of the people involved. We emphasized that this knowledge was to be used not to "diagnose" or "treat" Annie, but rather to supervise her effectively. But what did this mean to Eileen? She spoke feelingly of her guilt as she once again detailed the many hardships in Annie's life, not the least of which were financial concerns. Plaintively Eileen asked the group, "How do you draw the line between therapist/client, supervisor/supervisee, supervisee/program parent? To what lengths should we go to help?" We pointed out the hazards of replacing the guilt or anger one experiences as a supervisor with the illusion that one can rescue or provide therapy for the supervisee. What is needed, rather, is total respect

for the staff member. This is demonstrated by the supervisor's honesty and forthrightness about a problem.

Eileen needed to tell Annie that her current behavior was not acceptable in the workplace, understanding that this behavior was not good for Annie either. Eileen had to realize, believe, and convey to Annie that she was young and could make changes in her life. The Employee Assistance Program was there to help her. Meanwhile, Annie's behavior had to change. If it did not she could not remain in her job. As supervisor, setting clear limits, clarifying expectations, and giving the struggle and need for change back to Annie, Eileen could perhaps alter the predictable interactions and "endings" set up by this young woman. Eileen would not "cut Annie off" but would rather shift responsibility back to her and give her the opportunity to change her behavior (and interrupt repetition of self-defeating patterns from the past.) Such a respectful and positive supervisory option would both value Annie's potential and, by establishing limits and expectations, protect children and staff.

The group discussed our inability to "make" people function appropriately. We do not have that power with supervisees or with families and their children. To act as if we do is a trap—in any relationship.

Meanwhile, Polly .....

Polly, another member of the group, was visibly distressed by our focused questioning of Eileen. When we raised this with her at the group's next meeting, she said that she was upset primarily by our questioning of Eileen's motives and identifications within her workplace. She was quite angry at the leaders for taking such an approach. As difficult as this conflict was likely to be for the group so early on, we were pleased to have such strong emotion expressed. We believe that supervisory arenas are an appropriate setting for expressing and considering the range of human emotions—including anger. A quasi-group supervision was now in motion. For not only Polly was angry. Down deep, Eileen was too.

We do not have the power to "make" people—supervisees, families, or children—function appropriately. To act as if we do is a trap, in any relationship.

As leaders, we worked to understand the depth of Polly's anger. In our review of this second seminar session, we also reflected on whether we had in fact been too critical, too realistic, too fast. For a little while we too were struggling with self-doubt. (Joint leadership of the seminar, which at first seemed like a luxury, proved important and valuable at every group turning point. Similarly, consultation can offer an administrator/supervisor an arena in which complex and emotion-laden decisions can be processed.) With confidence re-established through our discussion, we made the decision to continue our search with Polly.

When the group met for the third session, Polly's anger was on the table. We asked her why she was so upset by our probing of Eileen's identification with staff. One of the major issues that soon emerged was her fear of being assessed negatively by the people she supervised. Of course assessment goes on all the time on the team (although rarely voiced), between parents and professionals, and between professionals. Polly, a very wise and immensely talented woman, began to get in touch with the connections between her staff's behavior and her own ambivalence about her current job.

The group listened with great interest as the tale of Polly's career history unfolded. Polly had recently made a choice between two jobs, each with its own merits and difficulties. Currently she was struggling with the choice she had made. As the problems involved in taking over her hospital program increased, the job she had rejected looked more appealing. Awash in her ambivalence, Polly was unable to see that her own struggle was affecting her staff. The staff's anger was expressed in a series of unsigned memos that appeared in Polly's mailbox regularly. An example: "There's more trouble here than you will ever know ..." Staff also seemed to be using time as a medium for expressing the lack of cohesion Polly felt: scheduling meetings and team appointments was becoming problematic. Polly was working non-stop to ensure funding for her program and good relationships within the hospital, but nothing she did felt like enough. Staff seemed to show little appreciation for her efforts and certainly no empathy for her predicament.

We suggested that Polly bring up these issues with staff and confront them with the strange variety of indirect communications she was receiving. As our seminar sessions continued, the group became relentless in checking in with Polly at every meeting to see whether she had followed these suggestions. She could not escape! Clearly, to assert herself strongly by announcing that all unsigned memos must stop, and that staff were expected to be on time for meetings, caused Polly considerable anguish. Over time, and with some pain, Polly began to realize that she was having difficulty asserting her expectations because she wasn't sure if, in fact, she did want to "own" the program. We were convinced that until she clarified her expectations with staff she could not be effective or have pleasure in her job, no matter how hard she worked.

Toward the end of the seminar, Polly began to interfere directly with her staff's indirect communication and veiled, if unsubtle, opposition. As she made clear statements about work expectations, staff began to experience Polly's leadership. The norms, guidelines, and limits that she increasingly articulated, first in the seminar and later with staff, were, in essence, the philosophical tenets of a program design that she believed in.

Eileen, Polly, and company

These two vignettes from the supervision seminar illustrate how issues presented by one member become entwined with the concerns of another. As the nine sessions take place, over the course of about four and one-half months, members continually tell their colleagues about changes or further understandings of their

jobs as they occur. At the conclusion of a seminar, members often set a date for a reunion to be held several months later. In Polly's words, "If feelings between people were like strings, the (seminar) room was like a great bowl of spaghetti."

Reflections on supervision and the seminar for supervisors

In order to work successfully with families, professionals have to be able to establish personal relationships with the people they serve. Not surprisingly, the complexity of professional relationships has emerged as the overriding theme of each of the supervision seminars held over the past three years.

As we saw in the vignettes, difficulties with anger, assertiveness and aggression permeate the seminars. While assertiveness is critical to leadership, people in positions of authority—especially women in the "helping" professions—are clearly not always comfortable with it. While the supervisors who participate in our seminars are generally able to be supportive and empathic to their staff members, they often have trouble recognizing the anger they are experiencing, being clear about expectations, and establishing and enforcing rules so that expectations are met.

Through our comments in the seminar and, most importantly, through the experience of the seminar itself, we offer participants a model of supervision that supports professional growth in staff and furthers the achievement of program goals.

Through our comments in the seminar and, most importantly, through the experience of the seminar itself, we offered participants a model of supervision that supports professional growth in staff and furthers the achievement of program goals. Key elements of this model are clear program goals and expectations, an explicit supervisory contract, and an awareness of the purposes and boundaries of the supervisory process.

Clear program goals and expectations

The mission statements of many programs serving infants and their families are framed so broadly that staff cannot hope to meet them. A general goal of "helping families" might be understood variously as involving the transmission of a body of knowledge (or advice) to parents, providing "support" and/or friendship networks, helping to ensure families' well-being during times of stress or crisis, offering job training, or intervening directly to reverse the consequences of maladaptive parenting. Administrators and supervisors must articulate and clarify their program philosophy and goals—and then uphold them. Only when program goals are defined can supervisors help supervisees become more aware of what they really think and believe, and how that squares with program goals. The supervisee is then also in a better position to know what to expect from program participants.(We should note that when some members of the supervision seminar became aware of the discrepancy between their personal philosophy and the philosophy of their program, they chose to leave their jobs.)

The supervisory contract

The seminar group spends its first session listening to what seminar members want to accomplish. We, as leaders, share our philosophy, goals, and procedures for the group. This mutual sharing of expectations is the first, necessary step in any supervisory experience. This process is what the social work literature refers to as "contracting" in supervision.

A contract is a binding agreement made between two or more parties. The contract between supervisor and supervisee clarifies the boundaries and responsibilities of this unique relationship. The supervisory contract is the vehicle through which the work of the supervisee is examined, explored, reviewed, pursued, and changed. The supervisor also continually examines, explores, and changes herself. The supervisee is responsible for "bringing in" her work and sharing her ideas and feelings about it. The supervisor is responsible for creating an environment in which such "risky" sharing can take place; she pursues and focuses on conflict, rather than avoiding it. The supervisor thus helps the supervisee achieve new levels of mastery, both of personal conflicts aroused by the work and of skills needed to accomplish the work itself.

We use the construct of the mutual contract throughout the seminar for supervisors at two levels. First, we invite group members to clarify what contractual arrangements they have or have not made with their staff; second, we use the contract model to establish parameters for what goes on in the seminar itself. As we have suggested, many people in supervisory positions in programs serving very young children and families have not themselves had a supervisory experience in which the powerful feelings evoked (and the personal psychological issues *re*-evoked) by such work were addressed. Our seminar offers this experience. And just as a child learns to comfort and regulate himself through a relationship with someone who has regulated and comforted him, supervisors can be more effective if they themselves have experienced a supervisory process that promotes mastery of conflict.

Purposes and boundaries of the supervisory process

The distinctions between supervision and therapy and between supervision and consultation arose as issues in our group. While at times the seminar took on a therapeutic character, we remained cognizant of the different purposes of supervision and therapy. The therapeutic contract suggests the need to address underlying personality problems; therefore, the therapist may need to make conjectures about underlying dynamics. The purpose of supervision is helping the supervisee to learn how to be her best professional self, in order to provide the best possible service to children and families. While supervision sometimes includes dealing with the supervisee's personality and unconscious dynamics, they are not the focus of supervision. The worker's dynamics are addressed only when they interfere with the work.

When a supervisor makes a psychological interpretation to a supervisee, one must question whether or not the comment is an angry attack disguised as psychotherapeutic "help." A supervisor who is clear about program goals and expectations should be able to set appropriate limits for the supervisee and wonder aloud with the supervisee how to help her within the terms of their contract. The supervisor then brings the problem back into the supervisory situation and thus provides an opportunity for helpful change through the interaction between herself and the supervisee.

This is very different from trying to meet the supervisee's possible need for psychotherapy. While supervision is designed to help effect "inner" changes in the supervisee, these are limited to changes in skill and in the use of the professional self. Of course, professional growth is likely to have an impact on other aspects of life and on other relationships, but these areas are not themselves an appropriate focus of supervision. Like the therapist, however, the supervisor must find a "stance"—some proper distance from which she can be genuinely empathic yet not over-involved. The supervisor must be able herself to experience strong emotions and to resolve conflicts, so that the supervisory relationship she offers will be able to address the complex and difficult issues with which staff—and families—struggle.

Just as supervision differs from therapy, so it differs from consultation as well. One of the major tasks of the supervisor is to make judgments and evaluate the supervisee's job performance. Consultation, on the other hand, is a voluntary relationship. The consultant does not have the supervisor's evaluative responsibility.

As leaders of the supervision seminar, our role is that of consultants who *model* the supervisory process. In the time-limited nine-session format, the process raises participants' personal issues so quickly and intensely that two leaders are necessary. One leader is free to pursue content issues, while the other is always available to monitor the process. The leaders take turns with these roles, depending on the particular expertise required and the relationships that evolve in the group. The leader who questions, probes, and uncovers conflicts can be forthright and single-minded, knowing that her partner is taking the role of protecting group members. As the leaders review the process of each seminar session together, they are better able themselves to reach a stance toward the group that is empathic but not over-involved. The entire process is designed to allow problems to be pursued, not avoided. Because leaders are open to, and accept, the whole range of feelings, the group members are helped to accept their own feelings, those of their supervisees, and those of the families with whom they work.

We have found that it works well to have as leaders of the seminar an administrator and an academic, both of whom are also clinicians. The administrator brings a working knowledge of service systems and experience supervising staff in a setting where the major goal is providing the best possible service to the client. The academic brings theoretical knowledge and experience supervising students, where the major goal is promoting their learning, including self-knowledge. This combination has helped us to balance our attention in the seminar between administrative concerns and problematic aspects of relationships.

Feelings of anguish and insecurity about making difficult decisions are illuminated and normalized for supervisors by the experience of sharing problems and discovering the commonality of both systemic and personal difficulties.

The supervision seminar as a model for the field

We think that the supervision seminar offers a promising model for the field of work with young children and their families. In their evaluations of the seminar, participants say that the group serves as a needed and valued support. Feelings of anguish and insecurity about making difficult decisions are illuminated and normalized for supervisors by the experience of sharing problems and discovering the commonality of both systemic and personal difficulties.

Obviously each participant takes something different away from the seminar. Some feel validated as supervisors and/or administrators. One member remarked, "The leaders gave me the nerve to change—to assert myself. It's not too much to say this has changed my professional life." Other members use the seminar to take a closer look at their expectations of themselves and of those with whom, and for whom, they work. Still others come to new understandings of the supervisory process as a relationship, rather than simply a mechanism for evaluation; they realize the need to examine what lies underneath behavior.

Many participants pursue continued consultation for themselves once the seminar is over. One member said, "I wouldn't dream of not providing supervision for my staff, yet it never occurred to me that I needed it for myself." Another concluded, "Before the seminar I didn't think I could afford to pay for consultation. Now I know I can't afford *not* to."

People who work with infants and their families face multiple levels of difficulty. We believe in and respect the desires of these professionals to do meaningful and effective work—and their capacity to grow and change in order to do so.

The authors would like to thank Linda Gilkerson not only for having a wonderful idea but also for her insightful comments on an earlier draft of this article.

National Center Notes

by Eleanor S. Szanton

This issue of *Zero to Three* reflects what we are learning about the importance of supervision as an aspect of training for practitioners from a range of disciplines who are working or preparing to work with infants, toddlers and their families.

NCCIP has been interested in training issues since the organization was founded in 1977. At that time our founders were greatly concerned about the relative dearth of professional expertise about infants and families. Our first National Training Institute in 1979 represented a beginning response to this concern. As we hold our Seventh Biennial National Training Institute in 1991, bringing together professionals who work with infants, toddlers and their families in diverse settings and in all parts of the country, we are gratified that our national institutes clearly meet a need.

The NCCIP Fellows program, begun in 1981, was a second response to this felt need for training. Regional institutes, held in various parts of the country in co-sponsorship with local or regional collaborators, were a third.

Nevertheless, it became clear early on that brief conferences have severe limitations. They sensitize and expose, and allow for interchange, informal learning and general "recommitment of passion," but they cannot provide in-depth training. For this reason, in 1987, NCCIP held its first intensive seminar in New York City, followed by another in Chicago in 1988. Each proved to be a catalyst for local efforts at training and networking. Intensive training with follow-up was the model for our 1990-91 Training of Trainers Intensive Summer Seminar.

NCCIP has also worked toward improving the training of infant/family practitioners by convening small groups of experts to help us develop and disseminate materials about best practice in training for work with this population. The 1988-1990 Training Approaches for Skills and Knowledge (TASK) Project issued reports directed toward four audiences with a stake in better training—professionals, parents, educators and trainers, and policymakers.

NCCIP's current Learning through Supervision and Mentorship Project is another such initiative. It grows naturally out of the TASK project's strong recommendation that individualized supervision be a key element of preservice and ongoing training for all infant/family practitioners. NCCIP's 1990-91 Training of Trainers Intensive Summer Seminar also made us aware of the need to understand differing conceptualizations and experiences of supervision and mentorship within the professional disciplines concerned with the zero to three population.

In fact, the approach used in the TASK and Learning through Supervision and Mentorship Projects has been employed repeatedly by NCCIP over the years. Issues as diverse as (1) What we mean by (process as well as outcome) program evaluation; (2) What we can agree on vs. what we still need to research on the question of the possible ill effects of child care on infants; (3) What we know about how states should approach the screening and assessment of infants and toddlers for eligibility under Public Law 99-457; and (4) What we can say about the diagnostic classification of very young children with actual or potential mental health problems all have been subjected to intense scrutiny, usually over a period of time, by a small multidisciplinary group drawn from NCCIP's leadership and other experts. The result has been the forging and refining of shared perspectives, which we then disseminate as broadly as possible through NCCIP's publications and public education activities.

We deeply appreciate the support of those public and private funders who have allowed us to do this work. We hope that our efforts will help to create a solid infrastructure for sound practice with infants, toddlers, and their families.

* * * *

We are very pleased to announce that Beverly Robersen Jackson, Ed.D. has joined the staff of NCCIP as our new Director of Public Policy and Public Education. Dr. Jackson has most recently served as Senior Public Policy Analyst at the National Black Child Development Institute. Prior to that time she directed the Department of Human Welfare for the United Methodist Church. She has a degree in education from Columbia University. Her long history of concern and activity on behalf of children is well known and much admired. We feel fortunate to have her with us.

Publications:

Parent/Toddler Group: A Model for Effective Intervention to Facilitate Normal Growth and Development (1990) - Phyllis Rothman and Irene van der Zande with the Early Childhood Center Staff, Thalians Mental Health Center, Cedars-Sinai Medical Center (The Early Childhood Center, Cedars-Sinai Medical Center, 8730 Alden Drive, Room E-105, Los Angeles, CA 90048) $21.95 plus $1.50 per copy for shipping.

The Parent/Toddler Program of the Early Childhood Center at Los Angeles' Thalians Mental Health Center involves support groups in which parents meet to discuss issues with a trained facilitator while their children play under the supervision of Child Development Interns. The Program emphasizes "helping parents to provide a clear, firm, but emotionally warm and empathic structure for their children, in order to maintain a stable, trusting, predictable attachment." This publication is a training manual based on the specifics of the Parent/Toddler Program but designed to inform a variety of efforts in the field of infant/toddler mental health.

The manual describes: the Parent/Toddler Program's model for intervention; developmental issues for children and parents during toddlerhood; recommended routines for common concerns such as sleeping and eating, handling transitions, and limit setting; handling special problems through a process of definition, a plan for intervention within the group, and a home plan; structure and organization of parent/toddler groups; the training

of child development interns; and group supervision. The chapter on group supervision includes vignettes on issues arising from Parent/Toddler Group material and on issues relating to planning processes and staffing.

Home Visiting: Procedures for Helping Families (1990) - Barbara Hanna Wasik, Donna M. Bryant, and Claudia M. Lyons (Sage Publications, Inc., 2111 West Hillcrest Drive, Newbury Park, CA 91320) $16.95 softcover.

The authors of this volume have been involved in home visiting since the 1970s, as home visitors, as trainers of home visitors, as developers of home visiting programs, or as consultants. Their book represents an effort to define models of best practice: it addresses helping skills and techniques, guidelines for first visits and final visits, and visiting families in stressful situations. In discussing professional issues facing home visitors, the authors explore both home visitor/client issues, such as values conflicts, confidentiality and the limits of appropriate intervention and issues concerning the profession, including professional burnout and multidisciplinary team approaches to work with families.

Wasik, Bryant, and Lyons discuss the credentials, training, and supervision of home visitors in some detail. They suggest that role playing, experiential learning, and peer teaching are effective, interrelated training procedures. They authors recommend that supervision ("a relationship with another person that fosters professional growth") be regularly provided for all visitors to provide feedback and support in a stressful occupation, maintain objectivity and professional competence, and prevent "program drift" away from specified objectives and goals. Individual, group, and on-site supervision models can all be used to advantage. The authors further recommend that professional training programs begin to prepare individuals to assume supervisory roles in home visiting programs.

Effective Supervision: A Task-Oriented Model for the Mental Health Professions (1990) - D. Eugene Mead (Brunner/Mazel, Inc., 19 Union Square, New York, NY 10003) $22.50.

In order to oversee the performance of a therapist trainee with actual clients, the author of this volume suggests, the supervisor must be able to observe, conceptualize, and intervene at three levels: the client level, the therapist-client level, and the supervisor-therapist-client level. Mead's Task-Oriented Model of supervision is designed to provide a theory of supervision that is independent of the various theories of therapy. The model articulates the parallel sets of tasks that must be accomplished by the client, the therapist, and the supervisor.

Mead encourages supervisors to develop a supervision plan that addresses: the supervisor's preparation for supervision, the conditions and expectations for supervision, the supervisor's understanding of the therapist's preparation for therapy, the goals to be achieved in a training period, the procedures the supervisor will use to observe treatment delivery and impact, the procedures the supervisor will use to determine the therapist's clinical reasoning and decision making, the procedures the supervisor will use to evaluate the therapist's progress,

NINA SUKUMARAN

and the procedures for intervening by the supervisor. Mead sees the overarching goal of supervision as helping the trainee to practice therapy that is ethically and professionally sound, and to develop a personal theory of therapy best upon the best available clinical research and theory.

Emotional and Sensory Processing Problems: Assessment and Treatment Approaches for Young Children and Their Families (1991) - Susan S. Poisson and Georgia A. DeGangi (Reginald S. Lourie Center for Infants and Young Children, 11710 Hunters Lane, Rockville, MD 20852) $10.00. Videotape also available.

This manual, developed by staff of the Reginald S. Lourie Center for Infants and Young Children through a cooperative agreement with the U.S. Maternal and Child Health Bureau, is designed to offer practitioners family-centered approaches for the screening and diagnosis, assessment, and treatment of children who have or are at risk for emotional and sensory processing problems and corresponding developmental delays. In addition to providing a theoretical framework for understanding sensory processing and emotional development in very young children, the manual offers two screening instruments: 1) a **Symptom Checklist,** validated on regulatory disordered and normal groups of children, listing signs or symptoms that may be indicative of problems in sensory processing, attention, and attachment; and 2) a **Comprehensive Parent-Child Screening Profile** that examines relative strengths and needs in the child, dyad, and family, as well as other factors affecting the child's developmental progress.

The volume describes three clinical intervention model programs the Fussy Baby Clinic, the Parenting Psycho-

therapy Program, and the Therapeutic Nursery and Preschool Program, depicting the application of each program's philosophy and goals through the use of composite case studies. Emphasis in the case descriptions is on the professional's thought processes and integration of new information into intervention planning as families and children develop, and new data emerge.

Child Care, Parental Leave, and the Under 3s: Policy Innovation in Europe (1991) - edited by Sheila B. Kamerman and Alfred J. Kahn (Auburn House, 88 Post Road West, Westport, CT 06881) $42.95.

This book about public policy support of parenting, with a focus on infants and toddlers, is the result of a two-year process of interchange among American experts and authors in Austria, Germany, France, Hungary, Finland, and Sweden. The work was supported by the Ford Foundation and the Smith Richardson Foundation.

The European countries described in this volume have responded to demographic and social trends, such as the increase in the proportion of mothers in the labor force and the continued economic vulnerability of families with young children, by targeting special policies toward families with infants and toddlers. The European policy package tends to define infant care as care by a parent who is home on a paid and job-protected leave for much of the first year following childbirth and a menu of policy options for care of one to two-year olds, with universally available group child care for children older than two-and-one-half years. These parenting policies build on a long-established social infrastructure for families with children that includes national health insurance or services and child or family cash allowances. Kamerman and Kahn suggest that we in the United States will need to design our own parenting policies and monitor our own results. They recommend that particular attention be paid to *universal* parenting and child rearing benefits, an approach seen in most of the European countries described and one that may find widespread political support in this country.

Parent-Child Relations throughout Life (1991) - Karl Pillemer and Kathleen McCartney, editors (Lawrence Erlbaum Associates, Inc., Suite 102, 365 Broadway, Hillsdale, NJ) $49.95.

The 13 chapters in this volume are papers presented at a 1989 conference that brought together psychologists, sociologists, and anthropologists who were interested in parent-child relations at different points in the life span. The editors (a sociologist who studies aging and a psychologist who studies early childhood) note that researchers on child development and social gerontologists have heretofore worked in isolation from each other. Nevertheless, several overarching themes concerning parent-child relations exist (and form the structure for this book). These are: parent-child attachment, transitions and their impact on parent-child relationships, relationships between and within families, and the influence of social-structural factors on relations between parents and children.

In a chapter on the parental side of attachment, Inge Bretherton, Zeynep Biringen, and Doreen Ridgeway describe their research using a parent attachment interview to gain insight into attachment related issues in mothers of two-year-olds. Carolyn Mebert discusses variability in transition to parenthood experience, suggesting that for some individuals and couples the transition may occur, psychologically at least, well before the baby is born. Looking at mothers' employment conditions, children's experiences, and child outcomes, Elizabeth Menaghan and Toby Parcel argue that maternal employment experience is influenced by the larger economy as well as by maternal characteristics, and that women are often restricted to positions relatively low in status, wages, and stability. They suggest that the quality of both the child's home environment and the child's out-of-home care are negatively affected by unsatisfying, unstable maternal employment and insufficient economic resources—with adverse effects on child outcomes.

Extending Families: The Social Networks of Parents and Their Children (1990) - Moncrieff Cochran, Mary Larner, David Riley, Lars Gunnarsson, and Charles R. Henderson, Jr. (Cambridge University Press, 40 West 20th Street, New York, NY 10011) $49.50.

In his foreword to *Extending Families*, Urie Bronfenbrenner suggests that this volume may well mark the beginning of a new stage in the study of social networks as field forces shaping behavior, belief, and development in human beings. Using their evolving theoretical conceptions of personal networks and the findings of the Comparative Ecology of Human Development Project at Cornell University, the authors examine the ways in which personal networks evolve and the roles they play in the performance of parents and the development of children. Of particular interest in our mobile society is the issue of whether friends can take the place of close relatives in providing guidance and support for the parenting role, and consistent feedback and advice to developing children.

The studies reported upon here examine the influences of race, class and culture on personal networks; specific issues related to single parents, fathers, and the networks of young children themselves; and changes in network resources and relationships over time. The description of the Syracuse, New York Family Matters Project constitutes a case study of the use of a family support program to stimulate the development of parents' personal networks. The authors suggest that policymakers consider ways to reinforce naturally occurring social systems used by families and communities to build on strengths and channel behavior, rather than focusing attention directly on families themselves. However, the authors state that the most important policy lesson to be learned from their research is that "if parents are to be supported on behalf of their own development and that of their children, ... public policies must give first priority to freeing parents, and those who will become parents, from the constraints of inequality and oppression, by ensuring the provision of adequate and sufficient education, employment, and humane housing conditions ... Freedom to grow, through schooling, work, and leisure activities will lead in turn to the social network connections that form the basis for healthy, productive communities."

Conference Call:

January, 1992

January 24-25: *The Department of Psychiatry and Behavioral Sciences, The George Washington University Medical Center* will sponsor an intensive course, taught by Stanley I. Greenspan, entitled "Infancy and Early Childhood: Clinical Approaches to Assessment and Intervention with Emotional and Developmental Delays and Disorders." The course will be held in Bethesda, Maryland. A one-day course will be taught by Dr. Greenspan on **February 22** on "Strategies of Clinical Intervention: Preventive and Therapeutic Approaches for Specific Types of Emotional and Developmental Disorders in Infancy and Early Childhood." This course will also be held in Bethesda. For information, contact The Infancy and Early Childhood Training Course, P.O. Box 15130, Chevy Chase, MD 20825, tel: (301) 652-9082.

February, 1992

February 5-7: A course entitled "Hawaii's Healthy Start: Making It Work for You" will be held in Honolulu, Hawaii, with 10 agencies participating. Presenters will include John Lewin, Richard Krugman, Calvin Sia, Anne Cohn Donnelly, and staff of the Hawaii Zero to Three Program, among others. Site visits can be arranged by appointment. Contact Hawaii Family Stress Center, 2919 Kapiolani Boulevard, Honolulu, HI 96826, tel: (808) 732-0000, FAX (808) 732-5718.

March, 1992

March 5-7: The *Children's Defense Fund* will hold its annual national conference in Atlanta, Georgia on the theme "Strong Children for a Strong America: National Choices, Community Strategies." Write or call the Children's Defense Fund, 122 C Street, N.W., Washington, D.C. 20001, tel: (202) 628-8787.

March 26-27: *The Conference Board* and the *Families and Work Institute* will hold their third annual conference in San Francisco (to be repeated **April 28-29** in New York City) on the theme "Work-Family Issues and the Work Ethic: New Realities, New Approaches." Sessions will address the process of developing a work-family agenda and creating systems to support the work-family agenda. Contact The Conference Board, Inc., P.O. Box 4026, Church Street Station, New York, NY 10261-4026, tel: (212) 339-0290; FAX: (212) 980-7014.

April, 1992

April 2-3: *The Massachusetts Early Intervention Consortium* will hold its 13th annual conference in Marlborough, Massachusetts, entitled "Incorporating Creativity into Early Intervention: Relationships, Humor and Commitment." Contact Carla Duke, Conference Chairperson, South Central Early Intervention, P.O. Box 202, Charlton Depot, MA 01509, tel: (508) 248-7816.

April 11: *Boston University School of Medicine* will sponsor a seminar in Cambridge, Massachusetts on "Dilemmas in Infant Growth and Nutrition." Stephen Pelton will be course director. Contact Continuing Medical Education, 80 E. Concord St., Boston, MA 02118, tel: (617) 638-4605.

April 12-14: *The National Center for Family Literacy* will hold the first national conference on family literacy at the University of North Carolina at Chapel Hill. The conference is designed for administrators, practitioners, researchers, and policymakers interested in developing and improving family literacy programs. Contact the National Center for Family Literacy, 401 S. 4th Avenue, Suite 610, Louisville, KY 40202-3449, tel: (502) 584-1133, FAX: (502) 584-0172.

April 30-May 3: *Save the Children/Child Care Support Center* will hold the fifteenth annual Family Day Care Technical Assistance Conference in Atlanta, Georgia. Kathy Modigliani and Ellen Galinsky will be keynote presenters. For information, write or call Save the Children/Child Care Support Center, 1340 Spring Street, N.W., Suite 200, Atlanta, GA 30309, tel: (404) 885-1578.

May, 1992

May 6-9: *The Family Resource Coalition* will hold its Fourth National Conference in Chicago, Illinois. Bernice Weissbourd and Marian Wright Edelman will be keynote speakers. For information, contact the Family Resource Coalition, 200 South Michigan Avenue, Suite 1520, Chicago, IL 60604, tel: (312) 341-0900, FAX: (312) 341-9361.

May 24-27: *The Association for the Care of Children's Health* will hold its 27th Annual Conference in Atlanta, Georgia, with the theme, "Building on the Strengths of Children and Families: Child Health Policy, Programs, and Practice." Contact Lee Ann Slayton, ACCH, 7910 Woodmont Avenue, Suite 300, Bethesda, MD 20814-3015, tel: (301) 654-1205.

June, 1992

June 15-17: *The Centers for Disease Control,* U.S. Department of Health and Human Services, and 12 other organizations, including the *National Center for Clinical Infant Programs,* will co-sponsor an International Conference on Child Day Care Health: Science, Prevention, and Practice, to be held in Atlanta, Georgia. The conference will be international scope and will focus on three major themes: child day care health, meeting the needs of children and caregivers, and translating science into practice. For information, contact Lillian Glickman, International Child Day Care Conference, PACE Enterprises, Inc., 17 Executive Park Drive, Suite 200, Atlanta, GA 30329, tel: (404) 633-8610, FAX: (404) 633-8745.

Zero to Three

is published 5 times per year. Subscriptions cost $18 per year, $35 for 2 years and $45 for 3 years. Subscribers may order additional copies of Zero to Three for distribution to staff or students at a rate of $5/auxiliary subscription/year.

For students, small organizations or others for whom the subscription fee is prohibitive, Zero to Three is available free of charge as indicated below:

☐ I would like to subscribe to **Zero to Three** for ☐ 1 year ($18) ☐ 2 years ($35) ☐ 3 years ($45).

☐ I would like to order _____ auxiliary subscriptions at $5 each per year. I understand that all copies of **Zero to Three** will be mailed to me.

☐ The cost of **Zero to Three** is prohibitive for me. I request a free subscription.

☐ In addition to my subscription, I would like to contribute _____ to support the work of the National Center. Contributions are tax deductible.

☐ Charge to: ☐ Master Card ☐ VISA $ _____ Account No. _____

Card Expires _____ Signature _____

☐ Enclosed is my check for $ _____. Please make checks payable to NCCIP and send along with this coupon to:

National Center for Clinical Infant Programs
P.O. Box 25494
Richmond, VA 23260-5494

Name _____

Mailing Address _____

_____

City _____ State _____ Zip _____

Professional discipline _____

Institutional affiliations (no more than 2) _____

_____

_____

Acct.#: 7911433677 3038/12/91

Zero to Three

National Center for Clinical Infant Programs
2000 14th Street, North, Suite 380 Arlington, VA 22201-2500

BOARD OF DIRECTORS
Kathryn Barnard
T. Berry Brazelton
Amy S. Cohen
Robert N. Emde
Linda Gilkerson
Morris Green
Stanley I. Greenspan
Robert J. Harmon
Irving B. Harris
Asa G. Hilliard, III
Anneliese Korner
J. Ronald Lally
Bernard Levy
Alicia Lieberman
Samuel Meisels
Dolores Norton
Robert Nover
Joy Osofsky
Jeree Pawl
George H. Pollock
Sally Provence
Kyle Pruett
Arnold Sameroff
Marilyn Segal
Rebecca Shahmoon Shanok
Jack Shonkoff
Albert J. Solnit
Lynn Straus
Bernice Weissbourd
G. Gordon Williamson
Edward Zigler

EXECUTIVE DIRECTOR
Eleanor S. Szanton

Nonprofit Organization
U.S. Postage
PAID
Washington, D.C.
Permit No. 2516

MOVING?
Be sure to notify Zero to Three of your new address. Third class mail is not automatically forwarded.

ADDRESS CORRECTION REQUESTED